

Career, Interrupted?

Psychiatric Illness and Women's Career Development in Aotearoa/New Zealand

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Ma sal at lende, for sore mush jins chomany that tute kek jins

From none disdainful turn, for everyone knows something which you have yet to learn

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Abstract

This thesis explores the experiences of a group of women in Aotearoa/New Zealand who have been diagnosed with a psychiatric illness, with the aim of gaining some understanding about how they negotiate issues around diagnosis, recovery and resilience-development and employment.

A qualitative methodology was used to encourage the women to relate their vocational and life experiences. Fifteen women, whose ages ranged from 17 to their late 60s, with a range of psychiatric diagnoses, were interviewed across ten months. One woman identified as having Māori ancestry and several identified as lesbian. Each interview, which was semi-structured, was transcribed and then verified by the women, and all data were analysed using thematic content analysis and symbolic interactionist and discourse/narrative analyses. Salient issues provided a focus for later interviews and generated theory.

The thesis is organised according to major themes that were generated from the data: 'Getting unwell and getting help,' 'Getting well' and 'Getting back to work.' Within these broad themes, key ideas emerged around the women's views on the difference between 'madness' and 'mental illness', the biological basis for mental distress, the impact of labelling, the importance of having a 'literacy' around psychiatric illness that helps foster agency, the importance of workplace accommodations and mentors in vocational settings, and the process of renegotiating vocational identity when one has a psychiatric illness.

Data analysis revealed how participants make 'sense' of their psychiatric ill health and recovery/resilience-development experiences, create a vocational self-concept and view themselves as social beings in the current socio-political and cultural context of being New Zealanders. The women's narratives exhibited negligible explicit gender role identification and the present research uncovered very little explicit data relevant to lesbian and bisexual women's lives, apart from data on sexual identity disclosure. Rather the women spoke as

members of a group that accepted Western diagnoses and used various strategies to reclaim what had been lost and grow new social and vocational roles.

The thesis, therefore, provides a platform for understanding the experiences of women living with psychiatric illness in Aotearoa/New Zealand. It provides new information on service-users' views of medical models of psychiatric illness and the efficacy of their alliances with mental health professionals. It also provides evidence of the needs women have for gaining and maintaining employment after diagnosis with psychiatric illness.

PART A – BACKGROUND TO THE THESIS

CHAPTER ONE

Introduction

This first chapter provides the background of the present study on the experiences of women diagnosed with psychiatric illness in Aotearoa/New Zealand. It also provides an explanation of the main purpose of the present study, an overview of the thesis content, a positional statement of the researcher and an introduction to the participants.

1.1 Background to the thesis

The personal stories of Kate Millet in *The Loony-Bin Trip* (1990) and Lizzie Simon in *Detour: My bipolar road trip in 4-D* (2002) were in my mind as I began the present study, as was the film *Girl, Interrupted* (Mangold, 1999), the stylistic convention of its title influencing the title of this thesis. These texts were powerful influencers of my views on psychiatric illness. One book, Millet's, was read at the beginning of my time working in the mental health sector in Aotearoa/New Zealand (1990) and the other, Simon's, was read at the end of my career in mental health (2002.) These personal stories, together with my own experience, rightly or wrongly, shaped my notion of what the 'truth' was about psychiatric illness for women.

Kate Millet's *The Looney Bin Trip* entered the collective imagination of the women's movement, fragmented and contested as that movement has been, as a pivotal piece of writing about women's experience of mental distress and psychiatric illness. Mental distress for women in this era might be perceived as the expression of *anomie* – a sense for women that their ability to express themselves and thrive in society as it was constructed was impossible. The women who charged this movement with its dynamism were those most likely to be perceived as not fitting the normative construct for women – for example,

lesbians. The normative fabric of society was woven in such a way as to give many women no sense of being able to thrive legitimately. Their behaviours and attitudes constituted a breach of social rules. Many Western women travelled as an adjunct to their husband's passport and could not enter into a hire purchase agreement without a male signatory in many places. Failure to thrive under these conditions had led to what has been culturally perceived as the 'valium era' of the 1950s housewife, 'mother's little helper' keeping her feelings of alienation¹ (from the situation in which she found herself) in check.

By the time of Millet's *The Looney Bin Trip* in the 1970s, anti-psychiatry was at its height and would remain a strong force through until the 1990s when deinstitutionalisation and the introduction of various standards of 'community care' in most Western countries were complete. In a sense Millet's *The Looney Bin Trip* is an autobiographical protest not only against medication and incarceration but also against psychiatric illness as a diagnosis. Millet wants to be allowed to manage her mental landscape herself and what comes across most powerfully is her resistance to the interference of others and her frustration that others deem themselves as more 'in the know' about her than she is herself. Also there is a profound sense of grief at other women attempting to have surveillance and power over her as well as distancing themselves socially from her and reading her as weak and to be contained.

In the new millennium, Lizzie Simon's account of bipolar disorder was widely read in the psychiatric service-user/consumer's movement in Aotearoa/New Zealand and showed a very different view of psychiatric illness and psychiatry from Millet's. There is more acceptance of medication and other treatments. Nevertheless, the struggle that mental distress/psychiatric illness still presents for a woman suffering from it is clear in Simon's writing:

The history of the inside of my head is the hardest to tell, because it is nonlinear, because it is fractured, because there are so many subplots, and because I have

¹ Alienation of this kind could invoke a feeling of being mentally distressed or acting 'madly'. Psychiatric illness while signifying a breach of societal norms of behaviour and thought (Turner, 1982) exists in relation to treatment and in this way is more socially acceptable/controllable a symbol than mental distress or 'madness' is.

spent so much of my energy in my young life hiding that history from the outside world. (2002, p. 4)

Both Millet and Simon tell their personal stories of experiencing life with a psychiatric illness powerfully and vividly. Krieschok, Hastings, Ebberwein, Wettersten and Owen (1999) note that personal stories operate as an organising principle in life histories and as such have proven a fruitful area of study.

To this end, the present study seeks to add to the growing body of sociological knowledge on women's life stories (Gould, 1980) and understand women's experiences of psychiatric illness and career development – work that, to date, has not taken place before in Aotearoa/New Zealand. 'Career' for the purpose of this study is taken to mean both, in a narrow sense, the sequence of jobs, occupations and study options undertaken by a person over the course of their working life (including schooling and retirement) and, in the broader sociological and contemporary career theory sense, one's entire life as being one's career with experience of mental distress being one facet in that career rather than it being a non-normative human experience. While the women in the study largely saw mental distress as a non-normative experience and 'career' as a vocational term, the present study aims to contextualize their experience into a more contemporary understanding of 'career.' To this end, the data analysed and presented in the chapters that follow, while looking at vocational experience in one chapter, look at the sociological 'careers' of the participants as users of mental health services in two other chapters, honouring their particular perspectives on psychiatric illness and career, while using contemporary theoretical approaches to understand these experiences.

According to Harre, an ideographic method of research, studying a smaller number of individuals one-by-one rather than large cohorts, "with [methodologically] no prior assumptions about the similarities or differences that may emerge among them" (1993, p. 219), can successfully create findings beyond a reaffirmation of the previously 'known'. It

was hoped that, by employing this methodology in the present research, new knowledge could be 'created' in the field. As Scull, Mackenzie and Hervey say:

In examining the lives of individuals, nothing precludes our attending to these broader structural and contextual concerns – indeed, to do so is essential if we are to really grasp the meaning and significance of their existence and accomplishments ... human action is always constrained by and responsive to the wider social and cultural context within which it occurs. In examining this constant interplay of structure and agency, we necessarily confront the inherently interactive and collective dimensions of each individual's life. Paradoxically, therefore, the very endeavour to capture what is particular and idiosyncratic about a given actor simultaneously requires us to attend most closely to the realm of the social ... the more we seek to understand the individual dimensions of someone's life, the more inescapably we find ourselves engaged in an essentially sociological enterprise. How else, after all, are we to understand lives and careers. (1996, p. 4)

The present study operated within a critical social science approach – looking at the participants' issues through examination of their social realities (Wight Felske, 1994.) Therefore notions of social justice underpinned analytical approaches being delineated as it is by citizenship, inclusion and equal opportunity. For this reason, the present study endeavours to offer a more "context-rich perspective on career exploration" (Blustein, 1997) – exploring both intrapersonal and societal factors influencing participants' careers. Questions in the present study grew out of the data provided by the women interviewed and were not imposed in a pre-determined fashion (Novitz, 1982.) Through an examination of their narratives in terms of their social realities, the present research found examples of loss, discrimination, empowerment and employment success in relation to women's experience of working or thinking about work, while living with a diagnosis of psychiatric illness.

1.2 Main aims of the thesis

The present research is multifaceted with a variety of aims. The main aim, using an inductive piece of research (Davidson & Tolich, 1999; Richardson, 1990), is to explore the career development issues of women who have experienced mental distress in the Aotearoa/New Zealand context. This will address an identified gap in the literature. There is little research on women, psychiatric illness and career development, and none on the topic in relation to

Aotearoa/New Zealand. The central tenets of life for persons with a disability are described as being economic marginalised and struggling for citizenship (Wight Felske, 1994.) The present study aims to explore both of these issues in relation to women in Aotearoa/New Zealand, not only to learn about disadvantages and struggles but also to look at strengths and opportunities. It aims to contribute to knowledge on psychiatric illness as lived experience and career, that is to say the relational and dialogical ways in which psychiatric illness experience is incorporated into identity formation and self-concept for those who have been diagnosed with it. It is not so much about how women *are* psychiatrically ill as how women *do* psychiatric illness in Aotearoa/New Zealand in the late twentieth century and new millennium. Not only is past lived experience researched, but also present contexts and future predictions and aspirations.

Pilgrim and Rogers (1999, p. 61) urge researchers to “focus more on the context and meaning of the cause and experience of mental health problems.” They urge researchers to look beyond the functional analysis of psychiatric illness as a social fact and look at “the relationship between agency and structure, when considering the gendered nature of mental health problems” (1999, p. 62.) It is this approach to studying women’s psychiatric problems that is used here.

Virginia Woolf (Bell, 1977), Kate Millet (1990) and Lizzie Simon’s (2002) accounts of mental distress, as socio-cultural narratives on women and psychiatric illness, helped in the development of a ‘hunch’ that some psychiatric illnesses were more ‘in’ than others with society and workplaces while others were more ‘out’ – ie, less accommodated for, less accepted, more problematised, and more prone to discrimination and stigma. It was of interest to the present research to see whether this was the case.

Individuals with disabilities have been shown to have interpretative abilities with which to shape their experience of their social world (Ferguson, Ferguson, & Taylor, 1992; Foucault, 1980; Oliver, 1996.) Looking at the world as experienced by the disabled shows us

that experiences are determined less by ontological reality and more by the “culture, values, beliefs and gender” (Ballard, 1994, p. 298) of social actors and the epistemologies (bodies of knowledge) (Oliver, 1989b, 1997) that inform them as dominant or contesting discourses (Ballard, 1994; Barton 1998.) The present study is a sociological one. It therefore looks at the larger socio-cultural and historical context in order to make meaning of the expressed inner life and sociological career, as well as vocational career, of women with a diagnosis of psychiatric illness in contemporary Aotearoa/New Zealand (Goffman, 1961; Wright Mills, 1959.)

Biology tells us that mental distress is due to chemical imbalance, religion that there may be negative spiritual forces, psychology that there is an emotional maladjustment, and sociology that socialisation has provided people with the basic interactional resources to label behaviours in various ways according to the time and place in which they are perceived. Since this is a sociological study, the latter is of most interest and for this reason other theoretical paradigms’ readings of women’s experiences of psychiatric illness in Aotearoa/New Zealand are not produced through analysis here. This allows for a rich study that purports to distil theory from lived experience. It provides data of sufficient depth that the analysis can be as complex and rich as the issues it examines.

1.3 Positional statement

In line with Patton’s view (1990) that the researcher needs to make explicit their positionality with regard to any piece of research, I shall be explicit in terms of my qualifications, beliefs and experience in relation to the topic being undertaken in this research. This is important since I am at the centre of the process of data collection and data analysis and this research is inflected with my theoretical stance. Sikes (2000) makes it clear that it is in the person and not the paradigm that corruption, whether unwitting or intentional, will exist. To guard against this, it is important to make clear the researcher’s own views and insights as distinct from the

participants' meaning making and be clear about the researcher's positionality and how their critical thinking is affected by it (Chiovitti & Piran, 2003.) As Smagorinsky says:

Intersubjectivity between researcher and participant appears to be a crucial factor in the social construction of data. It contributes to the degree to which researcher and participant grasp and build on one another's articulated thinking. (1995, p. 191)

The data collection process constituted an exchange at a particular juncture, in a particular political and economic climate, between me, the researcher, and other individuals, and both informant and research viewpoints and biases will have shaped the outcome of the research (Kearney, Murphy, & Rosenbaum, 1994.) I shall have constructed meaning from the data based on my experience in reading of the world. This will produce a different inflection on the findings than another researcher's experiences and reading might have produced. Since so much of the process is defined by my theoretical and socio-political perspective, it seems important both to explain who I see myself as being in the world and also to establish credibility with regard to my role, in no way as an expert, but as a valid researcher in this field and on this topic (Kingi & Bray, 2000; Scheurich, 1995.) The following therefore provides my positional statement in regard to the present research:

As a researcher I operate from a social constructionist orientation. My interest is in narrative and holistic approaches to research. Sociological and ethical frames to my work are important to me. After gaining an MA (Ili) from Oxford University in 1988, my first career was as a journalist in IT media and I went on to edit a computer magazine in London for the British Computer Society Inc and then moved into my second, related career of book editing. After immigrating to New Zealand, I became National Women's Representative on the National Council of the Journalists Union from 1992-94 and went on to be a Judge at the Peace Foundation's Media Peace Awards in 1999. My third career, brought about by my own experience of mental illness and suicidality, and a desire to contribute to the mental health sector from a service-user perspective, was in mental health resource development, mental health promotion and research into quality mental health service provision. In this career I edited and wrote a number of mental health publications.² My fourth career was as a graduate student at Canterbury University undertaking a BA Hons (I) in 2003 and then a PhD from mid 2004. With my PhD research, I wanted to research the experience of women living with psychiatric illness in a New Zealand context so that conclusions could be drawn that would influence policy and practice around careers service provision, thereby assisting people with mental distress experience in their career development planning.

² My publications in mental health are *Psychiatric Drugs and Their Side Effects* (Ed) (1997), *Mental Health - A Review of 1997* (Ed) (1998), *Stepping Stones - A Workbook for Users of Mental Health Services* (1999), *Beyond the Prescribed Limits - Poetry for Mental Health* (Ed) (2001) and *Self Help for Mental Health - Setting Up A Mental Health Support Group* (2001.)

Over the last 20 years that I have been involved in mental health sector training delivery and resource development throughout Aotearoa/New Zealand, I have been given the opportunity to observe the many changes that have occurred. One of the things I noticed in the 1990s, alongside the unrolling of deinstitutionalisation policy and practice in Aotearoa/New Zealand and a service user push for anti-discrimination campaigning, was that there was a significant increase in the use of new antipsychotics which had dramatic beneficial effects upon the experiences of those with psychotic disorders (Mond, Morice, Owen and Korten, 2003.) I recollect this occurring during my time undertaking quality monitoring of residential support services for people in the community with ongoing serious psychiatric issues like bipolar disorder and schizophrenia. Antipsychotic medications like olanzapine had a significant therapeutic impact in the psychiatric service user/consumer community in terms of enabling people to lead more integrated lives in the community. At the same time depression, post natal depression and anxiety were becoming more widely accepted in society, perhaps due to the increase in antidepressant uptake on the back of new SSRI medications that were far superior to the previous tricyclic antidepressants. Diagnosis of these disorders was also growing so that most people knew someone who had or was being treated with prozac and the like. The anti-medication/anti-psychiatry stance of the consumer movement in Aotearoa/New Zealand began to soften a little. This anti-psychiatry stance, borne of inpatient care and the terrible side effects of older medications, was one that had been imbued in me through my contact with those who had been involuntarily treated in hospitals, those who were active politically in the movement for deinstitutionalisation and due to my own experiences with outpatient psychiatry and the antipsychotic medication stelazine in the late 1980s in the United Kingdom. I come to the interviewing process of the present study with my anti-psychiatry stance intact.

1.4 Brief thesis overview

This thesis comprises six parts. Part A introduces the present study. It presents the thesis overview, the rationale for the research, the research background, the participants in the study, and the aims of the research. Part B, influenced by the data in the present study, reviews literature and research relevant to the two main topics of this research study – mental illness and career development. The section on mental distress and psychiatric illness looks at the history of mental distress in the Western world, its treatment and diagnoses. It also looks at psychiatric illness experience in Aotearoa/New Zealand, and the experience of women of psychiatric unwellness, in order to provide a context for the data produced in the study. The section on career development covers theories on career development (including details of career research in Aotearoa/New Zealand), career

development approaches towards the psychiatrically ill and career development issues for women (including a section on lesbian career development).

Part C firstly addresses the methodological issues in the present study. It looks at my interest as a researcher in the study, my own experiences and the gap in the knowledge base that this research is trying to address. It describes the reasons for using a qualitative methodology and presents an overview of potential theoretical constructions to be used, namely grounded theory, social constructionism, symbolic interactionism and narrative analysis. It addresses considerations such as researcher bias and participant wellness as well as ethical considerations such as informed consent, voluntary participation, right to withdraw, confidentiality, anonymity and dissemination of the research's results. Part C then explains the method adopted to conduct the present study. It describes the research tools used, the realities of the research experience as well as the process of gaining ethics approval.

Part D introduces the data generated by the present study – the women's narratives. It does so by presenting the three broad themes into which the data were categorised – getting unwell and getting help, getting well, and getting back to work. These sections reflect the narratorial style of the participants in which they all began their story-telling with their own or their older family members' mental distress onset and moved on to talk about diagnosis and treatment, telling others, recovering to a greater or lesser degree from symptoms and getting back into work (which in this case is broadly defined in career development terms as paid employment, supported employment, and skills training.) Participants portrayed their stories as linear and progressing towards wellness and this schema is used to introduce the data. Part E then summarises the main findings and provides a discussion around, and conclusions drawn from, the main points drawn out of the data generated. It then discusses implications for future research as well as providing recommendations and suggestions. Part F provides appendices (including references and a glossary).

1.5 Introduction to the participants

1.5.1 Introduction to the women

The women interviewed for the present study ranged in age from 17 to their late 60s. They displayed academic ability ranging from women with literacy issues to women with post-doctoral experience. Their psychiatric illnesses ranged from single episodes to chronic life-time conditions and from depression to psychotic bi-polar disorder. Their occupations ranged from unemployed status after working for several years as a shop assistant to an acting CEO and a former Member of Parliament. All of the women identified as P•keh•/tauwi. One woman had M•ori heritage but had been adopted at birth by P•keh• adoptive parents and had no knowledge of her M•ori whakapapa until later in her adult life. According to M•ori, she is nevertheless M•ori for as an often used whatakauki says: 'E kore e ngaro te k•kano i ruia mai i Rangī•tea.' ('The source of life derived from far off Rangiatea (in ancient Hawaiki) will never die' or 'It shall never be lost; the seed which was sown from Rangiatea').³ None of the women had Pasifika heritage. It is important to acknowledge that the experiences of the women in the present study are not the experiences of all women in Aotearoa/New Zealand but there is, interestingly, significant coverage of the narratives of lesbian woman (Novitz, 1990) due to the sample obtained by snowballing.

Of interest to me in the collective stories of these women is the number of them who have family members with experience of mental distress. Many had grandparents, parents or siblings with experience of mental distress. One woman's mother was the first person in Australasia to have a lobotomy. Another woman had a great grandmother who was a patient at Lake Alice psychiatric hospital for 40 years after experiencing post-natal psychosis. Of the 15 participants in the study, all had at least one family member or partner who has experienced mental distress/psychiatric unwellness. Several participants had several family members with such experience. The table below gives a visual idea of the extent of mental distress in these families.

³ This is a saying of tribes from the Aotea canoe. Rangī•tea is an island in the Society Group.

Table 1 - The participants' relatives with experience of mental distress

Pseudonym	Greatgrandparents' generation	Grandparents' generation	Generation above	Own generation	Generation below
Catnip		x	x	x	x
Celmesia				P	
Daisy			x	P	
Hawthorne	x	x	x (x)	P	
Hebe		x		x	
Hibiscus		x	x		x
Jasmine					x
Lily			x	x	x
Manuka			x		
Marigold			x		
Nikau	x	x	x	P	
Pohutukawa			x	P x	
Poppy			(x)	(x)	
Rose		x	x	P	
Wattle		x		P	

x = blood relative, (x) = non-blood relative (eg, sister-in-law, adoptive mother, step-father), P = partner (defacto partner, civil union partner or husband)

Several of the participants had experienced suicidal ideation, had family members who had committed suicide or had made suicide attempts themselves. Many women had what would be termed by psychiatry as 'co-morbid conditions' such as substance abuse, compulsive sexual behaviour, dyslexia, dyspraxia and anorexia. Also of interest was the range of psychiatric illness diagnoses my participants and their family members had, such as bipolar disorder, anxiety disorder, depression, agoraphobia, post traumatic stress disorder, borderline personality disorder, schizophrenia, post natal depression, and obsessive compulsive disorder. In this study, I came across psychiatric categories I had not previously known about such as scotophobia (fear of being stared at), emetophobia (fear of vomiting), housewife neurosis, and Scruples (religious paranoia).

The data provided by the women in the present study is significant because it covers a broad range of diagnoses and a wide age group and yet key themes emerge out of all of the women's stories that provide a coherent picture of contemporary women in Aotearoa/New Zealand in terms of their negotiation of psychiatric diagnoses and their pathways through work and career issues in relation to these diagnoses.

1.5.2 Vignettes

The women's stories in the present study were broken into parts and their complete story is never portrayed as a whole. This is because the data are organized into themes reflecting commonalities for some or all of the women in the participant group or reflecting significant interesting differences between different groups of women's experience. Since women are so often broken down into body parts and fetishised in some way in popular culture or the fine arts, I feel the need to represent the women at the beginning as complete selves. Therefore there are 15 vignettes, written by myself, to give a sense of the women as whole. Authored by me, they are still subject to my reading of them as women. I was concerned that by providing their own vignettes they would inadvertently reveal themselves in terms of their identities in a small country where so many people know one another. I would not have wanted to change their vignettes to 'hide' them again since such 'editing' would have seemed invasive to them in a study that has sought to leave their words as untouched as possible, save the anonymising of proper names, place names and corporations.

These vignettes are only snapshots which convey in general terms where the women live, what their occupations are or have been, the way they identify themselves (which can be in terms of age, ethnicity, socio-economic status, relationship status, sexuality, etc) and what the diagnoses are that they have been given by health professionals qualified medically to make such psychiatric diagnoses. The 15 vignettes provide a flat composite picture of the 15 women in the present study but nevertheless render them whole in some way, even if it is through the lens of my own perspective. For the rest of the study their stories will be dissected and stitched to those of other women (Ezzy, 2002) through thematic quilting to make a tapestry display of what the salient features are concerning women in Aotearoa/New Zealand's experience of mental distress and psychiatric illness and how it has affected their career development.

It was my decision to ask each of the women to choose the name of a flower as their pseudonym to ensure anonymity in line with University of Canterbury Human Ethics

Committee requirements. Some women chose shrubs or trees rather than flowers. Women have used plants for healing purposes for centuries and so selecting plant names as their pseudonyms seemed a fitting anonymising device. Also, I have always admired Georgia O'Keeffe's paintings of flowers and remembered her assertion that few people really see flowers because they are so small and because we have too little time to really stop and look at them. I wanted to take the time to see the flowers (ie, to see the women). I am aware of associations given by art critics of Georgia O'Keeffe's of her flowers representing women's bodies, though I am also aware that Georgia O'Keeffe disliked such associations. Postmodernism would say that her objections do not matter, that the reading of women's bodies into the flowers is still relevant. This argument aside, I am aware of these associations with flowers and women in relation to readings of her art and this also added to my own resolve to use flowers as representations of women who could not be named for ethical reasons. I wanted to avoid numbers and other reductive systems.

It seemed easier for me to hold an image of the plant name and the interviewee in my head, for example Daffodil substituted for Jane, than it would have been had they chosen another common name, for example substituting Claire for Jane. There was also the risk that one participant would chose another participant's real name for their pseudonym. Eventually I came to see the participants solely as their floral pseudonym as my memory of their actual name weakened. I have left their chosen flowers names in the final version of this thesis only in the vignettes which follow. They have been with me throughout the data analysis and writing up phases of the present study. In order to ensure that the women's comments cannot be stitched together by a reader to identify a particular participant, the flowers' names have now been removed from their comments in the text of the present study. The words of Colston Burrell (2009, para. 1), a prolific writer on gardening, unwittingly provide an apt summation of the process of using flowers as pseudonyms in the present study: "Once their seed is ripe, the flowers and foliage ... disappear."

Catnip

Catnip is a P•keh• woman in her early thirties with a male de facto partner. She lives in a city in the North Island and has a diagnosis of bipolar disorder. Catnip had a breakdown at the beginning of her second year of teacher training. She has had a wide range of jobs. Currently she works in mental health support. After one manic episode she had anxiety and depression for many years until two and half years ago she had another episode and has since been diagnosed with bipolar disorder. Her grandmother and two great aunts had depression. Her mother was diagnosed at age 12 with 'Scruples'⁴ (fear of the Devil and religiously based anxiety attacks.) Her father and aunt are on anti-depressants. Her uncle had a nervous breakdown at university. Her older sister was diagnosed with bipolar type II and bulimia as a young woman. Her older brother had a nervous breakdown while studying and has been on antidepressants, and her younger brother is on anti-depressants and is a drug user.

Celmesia

Celmesia is a P•keh• woman in her early forties in a civil union with a female tauiwi partner who also has a psychiatric illness. She lives in the South Island. As far as she is aware none of her family has experience of psychiatric issues and mental health services. She has a diagnosis of depression and has also had anxiety and scotophobia (fear of being stared at.) She has been diagnosed as an adult as having attention deficit disorder and this diagnosis has since been changed to one of specific learning difficulties, namely dyspraxia. She has spent some of her adult years in London and has travelled extensively. She has worked as a journalist. She is currently a Masters student.

Daisy

Daisy is a single heterosexual P•keh• woman in her late forties who has a casual relationship with a P•keh• man outside the city she lives in. She has two adult children by her ex-husband and lives in a city in the North Island. Leaving school and going on her OE at 18 she did a variety of jobs before settling into administrative work. Having undertaken tertiary study as a mature student to gain management qualifications, she now works as a manager in the mental health sector. She has a diagnosis of post traumatic stress disorder brought on by being a victim of a rapist in the 1990s. Her mother was hospitalised in the 1950s for psychiatric illness after a nervous breakdown and was given electric shock treatment.

Hawthorne

Hawthorne is a heterosexual woman of predominantly P•keh• heritage with some M•ori, heritage from her grandfather and great grandmother. She is employed as a school teacher and is completing a BA part-time. She is in the process of separating from her P•keh• husband who has psychiatric and alcohol addiction issues. She has three children to a previous husband, is in her early forties and lives in a city in the South Island. She was adopted at birth into a P•keh• farming family. She has a diagnosis of depression. Her birth father is a war veteran who became a drug addict during the war and went on to have paranoid schizophrenia. His father had depression. Two of her aunts from her birth family also have had depression. Her adoptive mother has been medicated for depression for many years.

⁴ 'Scuples' - no longer a diagnosis is understood today as a religiously-focused type of obsessive compulsive disorder that leads the sufferer away from orthodox obedience to God, through fear of the Devil, towards 'magical thinking' and non-sanctioned ritualistic behaviour

Hebe

Hebe is a single P•keh• bisexual woman in her early forties. She is divorced and has three children. She is currently on the domestic purposes benefit. She lives in a city in the North Island. Her diagnosis is of bipolar disorder. She is a trained kindergarten teacher. She feels her psychiatric illness was brought on by a nervous breakdown. She is in recovery from bulimia and compulsive sexual behaviour. She smokes marijuana. Her grandfather was hospitalised for depression and one younger brother has a diagnosis of schizophrenia and another has a diagnosis of depression.

Hibiscus

Hibiscus is a single heterosexual P•keh• woman in her late forties who shares custody of her children with her ex-husband. She lives in a city in the North Island. She has worked in apparel manufacturing, as well as working in peer support in the mental health sector. She has a diagnosis of depression and she also has arthritis. Her ex-husband suffered from depression. She thinks that her grandmother may have had a psychiatric illness and remembers her mother having a nervous breakdown during her teenage years.

Jasmine

Jasmine is a divorced P•keh• heterosexual woman in her mid seventies. She is still in touch with a M•ori man she had a relationship with after her divorce. She has three adult children, two of whom live overseas. She lives in a city in the South Island. She has a diagnosis of depression and also has arthritis. She has had a variety of administrative jobs over her working life. She is now retired. Her daughter also has a diagnosis of depression. She has a niece and nephew with mental health issues and a great niece committed suicide.

Lily

Lily is a P•keh• woman in her late forties with no children and a P•keh• male de facto partner. She lives in a city in the North Island. She is currently on the Invalids Benefit which is supplemented by a small paid position. She is active in voluntary work. Her mother experienced mental distress all her life and was admitted to inpatient services on occasion. Lily says that her mother has not been given a diagnosis though she was medicated with largactil and tricyclic anti-depressants. She also has a brother and a nephew with bipolar disorder. Lily's diagnosis was initially of depression and now is one of bipolar disorder.

Manuka

Manuka is a tauiwi woman in her early fifties who is married to a P•keh• man. She has one adult daughter from a previous marriage. She eloped to Aotearoa/New Zealand at sixteen having left school at fifteen. Originally diagnosed as having 'housewife neurosis' in the 1970s she eventually was diagnosed as having agoraphobia. She lives in a city in the South Island. Going to university as a mature student, she went on to become a university lecturer and left that profession to become a Member of Parliament. She has since studied law and undertakes research as well as writing columns for the media. Both of her parents suffered from alcoholism.

Marigold

Marigold is a seventeen year old single heterosexual P•keh• woman. She lives in a city in the South Island. A school student, she has been diagnosed with obsessive compulsive disorder, anorexia, depression and emetophobia (fear of vomiting.) Her family have told her that her uncle probably had bipolar disorder. She has a cousin with a psychiatric illness.

Nikau

Nikau is a P•keh• woman in her early fifties with an adult son and a long term tauiwi female de facto partner who also has experience of mental distress. She lives in a city in the South Island. Originally a teacher, she works in senior management in the health sector. One of her grandfathers died in long term residence in a psychiatric facility and her uncle, father and mother have experienced mental distress of various types. Nikau's diagnosis is one of depression.

Pohutukawa

Pohutukawa is a P•keh• woman in her early forties with a female de facto partner who also has experience of mental distress. She lives in a city in the South Island. She works as a support worker to the intellectually disabled. She has been diagnosed with borderline personality disorder and has a history of multiple suicide attempts. . She has dyslexia. Her half-brother committed suicide and her sister and father both had periods of inpatient treatment in psychiatric facilities.

Poppy

Poppy is a P•keh• woman in her late thirties who is married to a M•ori male partner and has one young son. She lives in a city in the North Island. Originally a school teacher she now works in health promotion. Her step-father has a diagnosis of bipolar disorder and her sister-in-law also has a psychiatric illness. Poppy's diagnosis was originally of post natal depression and is now of anxiety disorder.

Rose

Rose is a single lesbian P•keh• woman in her mid thirties. She lives in a city in the South Island. She has worked as a shop assistant, in supported employment for people with psychiatric illness, and is currently on the Invalid's Benefit. Her mother has a diagnosis of agoraphobia as did her maternal grandfather. Rose's diagnosis is of agoraphobia. She is currently learning to read.

Wattle

Wattle is a tauiwi woman in her early fifties with no children and a long term P•keh• female de facto partner who also has experience of mental distress. She lives in a city in the South Island. Wattle's diagnosis is of depression and she has history of drug abuse from which she is now in twelve step recovery. She has travelled overseas extensively and was working and eventually moved to Aotearoa/New Zealand where she currently works in management in the welfare sector. Her grandmother suffered from bipolar disorder.

1.6 Summary

In this part of the thesis, I have provided a background to the present research, outlined the main aims of the project and provided an overview of the parts of the thesis. I have also given a positional statement as a researcher and introduced the women participants. What follows next is a literature review for the present research that addresses both the literature on mental distress and psychiatric illness and on career development.

PART B – LITERATURE REVIEW

PART B

Introduction

This literature review is in two main parts – literature about mental distress and psychiatric illness and literature about career development. This is supported by material relating to rehabilitation and work. The data collected for this study informed what literature it was necessary to examine. The literature on mental distress and psychiatric illness aims to show the ways in which social knowledge and meaning making about mental distress and psychiatric illness has been negotiated and constructed over time. This is followed by the relevant career development literature in relation to women's experience and also the experience of the psychiatrically ill with regard to careers, though this latter literature is scant at best. For that reason, an overview of rehabilitation literature around work and psychiatric illness will be provided to indicate the kind of vocational interventions sanctioned by government policy with regard to the psychiatric ill. While most of the women in the present study did not undertake formal rehabilitation delivered by government and non-governmental services, there is still enough theory from the literature to be useful in understanding the data that this study produced.

CHAPTER TWO

Mental Distress and Psychiatric Illness

2.1 Introduction

The literature on mental distress and psychiatric illness, as with the literature on career development, is examined in order to help explain some influences upon the narratives of the present study's participants and how they are interpreted. It looks at what knowledge around mental distress has been constructed since it was first identified as a problem in the West historically. This allows "...reconstructing the epistemological field that allows certain things to be considered true at particular historical moments..." (Rose, 1999, p. *xiv*.) Rose asks: "how have persons been shaped by prevailing ways of thinking about human beings and acting on them?" (Rose, 1999, p. *xvii*.) The discussion of this literature examines the history of mental distress and psychiatric illness in the Western world as a journey in the production of social knowledge about mental distress and psychiatric illness (Sedgewick, 1982.) As Read (2004a, p. 9) says: "we can understand our present situation better if we review the past." The discussion of this literature also looks at mental distress and psychiatric illness in Aotearoa/New Zealand in the recent past and current millennium, including looking at the experience of, and influence of, the Indigenous population – Māori.

Human beings have had experience of mental distress and developed ways of addressing it for many centuries (Gupta, 1993; Pilgrim & Rogers, 1999; Sedgewick, 1982.) In Western tradition, it is understood not only through medical disease models but also through "philosophy, psychology, sociology, [and] even morality" (Neff, 2006, p. 208.) It is linked with depravity and transgression and is more sophisticated when viewed in human beings than it is in animals since issues of the 'mind' and of 'society' come into play in a way in which they seldom do in animal science (Neff, 2006.) Suffice to say, conceptualising mental distress in the human being is not an easy undertaking. However, observing how humans have striven

to deal with mental distress over time does give us an insight not into what mental distress and psychiatric illness *are* ontologically but how they have been *conceived of* epistemologically (Sedgewick, 1982.)

There has been much social fear of mental distress throughout the ages as well as attempts to romanticise it in the genius of artists and writers (Luhmann, 2000.) The medical profession has striven to categorise various versions of mental distress into psychiatric illness classifications and to treat it as a disease (Neff, 2006) and even cure it. This section will look at these factors and how they shape the context for experience of mental distress in the modern world. It should be noted that the idea of mental health has largely been seen as the absence of mental disease in a small number of 'pathologically' afflicted individuals. In recent times, through public health policy, mental health is ascribed to healthy emotional functioning in the general population and exists less as a counterweight to psychiatric distress and more as a barometer of healthy social functioning (Gupta, 1993, Pilgrim & Rogers, 1999.)⁵ Beyond noting this, it is beyond the scope of this literature review to examine mental health in this 'public health' way⁶ or to focus on what makes an individual happy and a society psychologically healthy.⁷ It is for this reason that the notion of 'recovery,' and the idea of 'resilience' that has developed from the notion of 'recovery,' are used rather than mental health in this thesis.⁸

⁵ For example, by 1947 the World Health Organisation defined health as more than the absence of disease (Hattie, Myers, & Sweeney, 2004.)

⁶ Public health promotion looks at strengthening individuals, strengthening communities and reducing structural barriers to mental health.

⁷ For anyone wishing to examine the epistemology of mental health, a good starting place might be Jahoda's rejection in the 1950s of mental health as an absence of mental distress. She developed what she termed 'Ideal Mental Health' (Lalitha, 2002.) The World Health Organisation also defined mental health in the late 1980s as an ability to function well in society and the physical world (Lalitha, 2002.)

⁸ Since the data for the present research has been collected in the first decade of the new millennium, it seems appropriate to use the notions of recovery which were adopted in the late twentieth century as a conceptual counterweight to mental distress in individuals. Developed from the recovery model is the idea of a strengths-based/resilience-focused approach to dealing with psychiatric illness. Recovery and resilience-development look at individual functioning across a variety of spheres including the world of work to view how an individual can be functional psychologically and thrive socially despite experiencing ongoing symptoms of psychiatric illness.

2.2 A history of the development of ‘mental illness’ and psychiatry

2.2.1 From the classical world to the Enlightenment

Links have been made between creativity in the arts and mental distress since ancient Greece (Gupta, 1993; Holden, 1987; Read 2004a) through to recent times (Jamison, 1996.) Stone notes that Plato’s student Aristotle developed “the concept of the Golden Mean (and deviations to either side)” (1997, p. 9.) Mania and its polar opposite depression (commonly called melancholia historically) have been identified by humans since the classical era of the Greeks and Romans (Sedgewick, 1982) in Western tradition. This shows that in Western thinking there have been attempts for many centuries to classify mental distress into discreet diagnoses based on symptomology. The fact that this endeavour is centuries old means that by the time of the present study the existence of mental distress and the classification of psychiatric illnesses into groups has taken on the semblance of ontological ‘truth.’ Whether it is ontologically real or not, such thinking about mental distress in society has become hegemonic in the West.

Stone (1997) notes that, from the time of Plato and on into the Middle Ages, mania – perceived as god-inspired by the features of its manifestation – could be accorded a role in religious practice, such as the revelatory mania of Julian of Norwich in the Middle Ages. A counterpoint to this was the mania perceived to be demonically inspired that could be punished by torture, expulsion or death (Read, 2004a.) A person’s role in society might influence the way in which their mania was perceived, such that a nun might be said to have experienced beatific visions but a pauper to have experienced delusions of grandeur. Scull, Mackenzie and Hervey (1996, p. 5) note that “people’s mental and moral capacities varied markedly according to the circumstances in which they were placed, and their thoughts and actions were, in the large degree, the product of an interaction between habits, situational pressures, and the influence and reactions of their associates.”

Manuals have been written on understanding the misery of mental distress by individual doctors since the time of the ancient Greeks (Pilgrim & Rogers, 1999; Shorter, 1997) and custodial institutions have existed since the Middle Ages. The longest running asylum⁹ was in the Priory of St Mary of Bethlehem (Gupta, 1993) which was to become known as Bedlam – a word which entered common parlance over time. Remarkably Bedlam existed from the thirteenth century until it was closed in 1948.¹⁰ Despite the existence of Bedlam since the Middle Ages and other public asylums in Europe, as well as some private madhouses, psychiatry and asylums only became the dominant system of dealing with mental distress from the eighteenth century (Hunter & Macalpine, 1963.) Up until 1800 the mentally distressed were kept predominantly at home by their families (Jones, 1972.) The asylums that had existed since the thirteenth century were used predominantly for lepers. Shorter describes British home ‘care’ as “a horror story” (Shorter, 1997, p. 2.) The notion of being ‘at home’ was a euphemism, for, in fact, the mentally ill might be shackled in pig sties, covered in their own faeces and half starving, rather than being housed in the main dwelling of the rest of the family.

Sometimes, if fate dealt them the unlucky hand of being born in Britain, they might be caste out to roam in their mentally distressed state and take to begging or die destitute. Only Britain legally allowed families to abandon completely their family member. The mentally distressed in the rest of Europe had the legal right to ‘care’ in the community in their home village.¹¹ As Shorter notes: “in contrast to the British tradition of private-sector custodialism, on the continent of Europe the public sector had always offered care” (1997, p. 5) though, as Turner (1987) notes, the village ‘mad cell’ was still a brutal place in which to be incarcerated. In short, the Middle Ages can be seen the era in which notions of ‘care’ of the mentally

⁹ Asylums enable the separation of violators of norms in society (Turner, 1982) and can be seen as what Everett Hughes termed ‘total institutions’ (Mitchell, 1978) – that is, “social institutions which were much more shut off from the outside world” (Burns, 1992, p. 142.)

¹⁰ Hogarth’s impressions of Bedlam have been criticized as too severe according to recent research (Shorter, 1997.)

¹¹ Even today home-based care can be a euphemism for abuse as was evidenced in the story of Giuseppina Gentilezza, a mentally distressed woman, who was kept in a darkened bathroom measuring 7 feet by 9 feet by her mother for 30 years in Pescara, Italy. When found, she was curled up into a ball on the tiled bathroom floor. She had been fed leftovers in dog bowls on the floor and was hosed down on the balcony, frequently beaten, and sometimes left out on the balcony in winter as punishment (Owen, 2006..)

distressed developed. It is also an era in which social factors and national differences can be seen to influence such 'care'.

In France in 1656, Louis XIV developed *hôpitaux généraux* (Gupta, 1993) which were custodial institutions for a mix of those identified as insane and also the physically infirm, homeless people and those convicted of criminal activity (Jones, 1972; Shorter, 1997.) In the 1800s in England and in Europe there was a push to introduce asylums on a grand scale (Read, 2004a.) Foucault calls this era the 'grand confinement' in his published doctoral thesis *Madness and Civilisation* (Dreyfus, 1987; Foucault, 1965; Gupta, 1993.) Shorter (1997) notes, however, that fewer than 5,000 people from a population of roughly 10 million were confined in asylums in England in 1826 as noted in national statistics from a census. The Enlightenment era coincides with more complexity in society's structures and a strengthening of nation statehood in the West and it is most likely that the Enlightenment rather than capitalism or the rise of central states provided the platform for psychiatry as it is practiced today.

Anti-asylum mentality is so firmly entrenched in modern Western thinking today that it is almost a given that 'total institutions' (Mitchell, 1978) for treatment of people with mental problems are bad for them (Szazs, 1970.) An Enlightenment interpretation turns this on its head. It shows institutionalization at that time as an intended reform, as an emancipatory push to heal the mental distressed that spanned nations and continents (Hunter & Macalpine, 1963; Jones, 1972.) Grounded in Enlightenment thinking throughout Europe, there was confidence among physicians that mental problems might even be eradicated (Shorter, 1997.) There is little common knowledge today of positive views of asylums historically (Read, 2004a.) However in the early 1800s reformists had advocated asylum care as the only way forward for dealing with the insane (Scull, Mackenzie and Hervey, 1996; Turner, 1987.) Since mental problems had not previously been conceived of as curable it had not previously been the preserve of physicians *en masse* (Jones, 1972.) The notion of custody itself being curative began to evolve over time, replacing the idea of

asylums merely being the holding pens of raging insane people (Shorter, 1997.) Therefore, by the 1800s, psychiatry was becoming a medical specialty accorded some respect as a curative art rather than the preserve of lay custodians who might chain, flog and keep the insane in unhygienic conditions with impunity (Hunter & Macalpine, 1963; Jones, 1972.)

During the French Revolution, Philippe Pinel was conscientised in revolutionary circles and took on Enlightenment psychology and a progressive stance on social reform (Gupta, 1993; Miller, 2000.) In 1793, he is famously said to have unchained inmates in one institution (Read, 2004a; Turner, 1987) and by 1795 abolished chains from another, replacing them with strait-jackets. He also believed that psychological therapy could be undertaken in the asylum. In York, Quakers set up a 'retreat' that opposed the use of restraint (Gupta, 1993; Miller, 2000; Read, 2004a; Turner, 1987.) This may have been influenced by Pinel's reforms.

Pinel published a textbook in 1801 (Pinel, 1962) in which he raised the hope that some of the insane – those who were lucid between episodes of insanity or who were convalescing after illness – could be cured and returned to society. He advocated warm baths, activity rather than idleness and systematic programmes of activity as well as cognitive work to restore reason (Hunter & Macalpine, 1963; Shorter, 1997.) Psychotherapy had arrived as those working with the insane moved beyond merely administering medicine or prescribing physical procedures such as cold baths, rapidly whirling chairs or blood-letting. The reformers spoke of engendering hope and reason in inmates, not just confining them. They looked to the character, culture, family problems and social situation of their charges. Haslam, medical officer of Bedlam, in what could be called a precursor to Rogerian notions of counselling, advocated a mild manner (Double, 2005), listening to the stories of the mentally disturbed and aligning oneself with the 'truth' of these stories.

This section is relevant to the present study because it shows how notions of symptomology, 'care,' treatment and a curative impulse took their place in the story of

mental unwellness in Western society. This is the beginning of a belief in the efficacy of treatment that could be both brutal (in the case of blood-letting and cold baths) and gentle (in terms of the Haslam's mild manner and the York Quakers' retreat method.) Complex views of diagnosis and treatment as both negative and positive for those who experience it can be traced back to this time and may be useful in understanding the views on treatment of the women in the present study.

2.2.2 The nineteenth century

Since the eighteenth century nervous illnesses such as anxiety and compulsive disorders have been gathered together as their own classification of illness. Shorter (1997) notes that these illnesses were with us for centuries just like the major ones of mania and depression. The ancient Jews had the condition 'love sickness' (Shorter, 1997), the sixteenth century in Europe had 'hysteria' (Turner, 1987) and the eighteenth century had 'nerves' (Hunter & Macalpine, 1963.) What is important about these disorders is that they did not belong in the asylum. They were treated through family medicine or neurology. These disorders only come under psychiatry's scrutiny in the nineteenth century and were eventually to make their way into the asylum for treatment, though the asylum was used mostly for the treatment of the poor with nerves and not the rich. Largely, patients with nerves were treated in private spas – the waters seen to be calmativ. Spas had their heyday in the late medieval period and had declined by the eighteenth century, but they regained prominence as society physicians began to specialize in 'nerves' and treatment of the gentry in every country in Europe (Shorter, 1997.) Psychiatry had begun to come out of the asylum and into society.

Social class clearly had a large part to play in one's experience of mental distress and treatment by the nineteenth century (Gupta, 1993; Hunter & Macalpine, 1963.) As Read (2004b, p. 161) points out: "mental hospitals have always been filled predominantly with poor people." There was less shame in having nerves than in being 'insane which is why the

upper classes were much more likely to suffer from nerves, the vapours or melancholy.¹² It should also be noted that gender also had a part to play in the experience of mental distress at this time. The medicalisation of the female body as frail, emotionally labile, uncontrollable, excessive and immoral in the 1700s and 1800s provided a powerful discourse for control of medicine, and surveillance of women, by men (Ehrenreich & English, 1978; Micale & Porter, 1994.) Both the social class and gender issues of treatment were not critically identified at this time by psychiatry, but family factors – embedded as they actually are in gender and social class issues – were identified in terms of the impact of hereditary factors upon mental distress.

Miller (2000, p. 11) notes that: “over the decades from 1808 many of the asylums became crowded. The condition under which inmates were usually cared for gradually deteriorated, and this was ignored.” For Shorter, the demise of the therapeutic asylum was based on sheer overwhelming numbers of patients undermining the therapeutic capacities of institutions. He is unhappy with other theoretical readings of the situation which place more blame on the desire of madhouse physicians to professionalise and credentialise (Abbott, 1988) and create their own area of medicine of equal weight and status to other medical specializations such as gynaecology and oncology. It is probable that both theoretical readings have merit and are not mutually exclusive.

In nineteenth century thinking, hereditary factors were crucially implicated in an individual's chances of experiencing mental problems. Importantly, some psychiatrists held Romantic notions of new curative and therapeutic factors in healing that would go on to influence twentieth century thinking and bring a return to the therapeutic imperative in psychiatric care, but the majority of psychiatrists, as has been noted above, did not share this view. At the beginnings of modern psychiatry in the nineteenth century, organic and

¹² Even as late as the 1970s a study of admissions into Tennessee community mental health centres has found that the professional classes did not seek state help in the way that non-professionals do (Colligan, Smith & Hurrell, 1977.)

genetic factors were clearly seen as the basis of mental distress and this gave psychiatry a biological framework of understanding.

What can be seen as the nineteenth century progresses is a growing tension existing between encroaching Enlightenment ideas that focus on reason and Romantic ideas that focus on feeling (Hunter & Macalpine, 1963.) The key feature of Romantic psychiatrists in the nineteenth century, who make up the most radical thinkers in psychiatry at this time, is that they were interested in the subjectivity of their patients. Esquirol is a forerunner with his writing on 'passions'. Johann Heinroth knew Esquirol and, coming from a theological background, was obsessed "with morality and sin" (Shorter, 1997, p. 31) and this showed through in his writings on mental problems. Eventually, psychoanalysis¹³ would reify the individual, reigniting Romantic ideas, championing curative possibilities and running counter to 'biological' psychiatry.¹⁴ The key feature of Romantic psychiatry in the nineteenth century is that it was largely involved in research and theorising rather than in policy and psychiatric practice. It remained the poor cousin to biological psychiatry until the time of Emil Kraepelin.

This section is relevant to the present study because it shows psychiatry gaining professional status and illness classifications beginning to proliferate as nerve disorders are brought under psychiatry's auspices. It also shows the way in which the asylum system began to exhaust its curative impulses and shows the beginning of psychiatry outside the asylum walls. Women's issues begin to be identified as separate mental health issues and the medicalisation and problematisation of women's bodies proliferates. This section shows how clinical analysis can label women as abnormal in certain respects in comparison to the male norm, or pathologise normative female bodily experiences. The power of the medical gaze grows here and this may be relevant to how the women in the present study perceive the power relationships they experience with those in the psychiatric and medical profession.

¹³ Personal and social factors are the basis of mental problems in this view. Freud would in the future be mortified to be associated with Romantic psychiatry, but the association grabbed the imagination of historians of psychoanalysis and the link is still made today (Micale & Porter, 1994; Shorter, 1997.)

¹⁴ Twentieth century psychiatrists would eventually place a client on a continuum somewhere between these two polar opposites (Hunter & Macalpine, 1963; Shorter, 1997.)

2.2.3 The twentieth century: Emil Kraeplin

Shorter (1997, p. 69) notes that “after 1900 the whole paradigm for looking at illness changed.” Research began explaining the link between brain and mind. Specific diseases began to be identified. German researchers dominated the field of university research and teaching in psychiatry at this time. Benedict-Augustin Morel promoted the notion of degeneration of psychiatric disease from generation to generation due to genetic factors. This led to the unfortunate use of negative eugenic experiments in sterilisation in the 1930s in the US and Europe and eventually extermination in the 1940s under the German National Socialist party and Adolf Hitler¹⁵ (Read & Masson, 2004.) Genetics became a dirty word after the Holocaust (Read & Masson, 2004) for several decades throughout Europe and America. This created a vacuum for a new way of thinking to fill.

Many would think that Freud fills this void but, while he influences psychiatry hugely and creates a schism between British and American psychiatric practice, he was a neurologist not a psychiatrist and he never saw psychotic clients (Hale, 1995.) His clients were those with what was once called ‘nerves.’ The rise of pharmacology and psychoanalysis would herald a return to a ‘therapeutic element’ in inpatient/asylum care and it is Emil Kraeplin who is the key figure in the transformation of psychiatry in the twentieth century. Kraeplin was interested in psychology as a part of psychiatry (Double, 2005; Grob, 1991, 1994.) He was able to receive a professorship in psychiatry at Hiedelberg where psychiatrists were not required to undertake neurology (Shorter, 1997.) Kraeplin was particularly interested in the trajectory of illness over the lifetime in people with psychiatric conditions. Out of this work came “the differentiation of distinct diseases” (Shorter, 1997, p. 103) based on outcomes for patients in terms of their illnesses.

Kraeplin had written a *Compendium* in 1883 and continued to update this. By 1893 it had grown from a nondescript publication to a crucial manual in psychiatry in which

¹⁵ As Shorter notes (1997, p. 99) “academic medicine in Germany on the whole stood waist-deep in the Nazi sewer, and bears heavy responsibility for the disaster that followed. By 1933, degeneration became an official part of Nazi ideology.”

schizophrenia was finally clearly outlined as a separate disease. He is responsible for shifting psychiatry towards predicting outcome – prognosis (Shorter, 1997.) It was also Kraepelin who renamed what had been called ‘circular insanity’ and called it manic-depressive illness (which has now come to be known as bipolar disorder.) Even more importantly, he managed to reduce psychiatric conditions – that had proliferated under biological psychiatry into symptom-based diagnoses – into two major camps: illness with an affective component and illness without an affective component (Bleuler, 1950.) As Luhrmann (2000, p. 13) notes “over the years, at least for the last few centuries ... certain strange miseries have recurred in the history and literature of madness.” By the turn of the century, Kraepelin had raised the profile of two illnesses above all others and they remain dominant today – manic depressive illness and schizophrenia (Kraepelin himself called the later ‘dementia praecox’.) This diagnostic feat had as powerful an impact on twentieth century psychiatry in terms of diagnosis as Freud’s contribution did in terms of treatment (Hale, 1995.)

Kraepelin’s 1899 version of his textbook formed the basis of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association which remains the dominant diagnostic tool today (Grob, 1991, 1994.) Kraepelin wanted to answer questions from family members and patients about the probable outcome of their disorder. This was a sophisticated endeavour in comparison to previous curative impulses in psychiatrists of previous generations. He wanted to look at discrete illnesses, not syndromes. What Kraepelin and his colleagues determined was that disorders that could be identified in the brain were neurological and those that could not be traced to a part of the brain were psychiatric. His was a medical view, if not a biological one, unlike the Freudian view which was biopsychosocial (Hale, 1995; Micale & Porter, 1994; Shorter, 1997.) Looking for the cause and cure of mental distress in the brain – biological psychiatry – would become predominant, as it is today, but the notion of the ‘mind’ was to become dominant for a while. In a sense this was positive since the laboratory and treatment rooms of asylums were to

lose their dominance and office-based psychiatry and a more person-centred approach would begin to develop.

This literature is relevant to the present study because it shows the beginning of modern psychiatry and the birth of the idea of degeneration, which, though discredited, still finds expression in the view that the mentally distressed are somehow subhuman or monstrous or lesser than their sane counterparts in society. Such a view will underpin a lot of discriminatory and stigmatising behaviour. Also, the proliferation of discrete illnesses under the psychiatric illness umbrella begins at this time and heralds the modern era with its variety of psychiatric illnesses. The women in the present study have many different diagnoses. This section on how diagnosis emerged helps establish the view that they must negotiate the stigma of such diagnoses and that there are differences in the levels of stigma experienced by women with different diagnoses, for example depression compared with schizophrenia.

2.2.4 The twentieth century: office-based psychiatry

Office-based, person-centred psychiatry has become particularly prominent in the US. However, it was not until the early twentieth century that European models became less dominant there and a distinctively American psychiatric tradition emerged. To outline psychiatry briefly in the US prior to the advent of office-based psychiatry in the twentieth century, the first lunatic asylum opened in Virginia in 1773 (Hunter & Macalpine, 1963) and, by the first decade of the nineteenth century, New York hospital opened a separate psychiatric facility. Dorothea Dix in the 1840s in New England was a social reformer who went throughout the countryside in Massachusetts auditing how people were treating the insane and she attempted through her work to transform the prevailing brutal conditions (Gupta, 1993.) Hers is one of the few stories of women impacting the mental health treatment landscape over the centuries. In 1869, the Willard State Hospital in New York State abandoned any therapeutic attempts. This was the first asylum to abandon curative

principles. By the 1880s all mental asylums in the US had become merely custodial (Grob, 1991a; Grob 1994.) The reason for this change was the growing number of patients in the system and new views on the genetic determinants of psychiatric illness and notions of degeneration from proponents of eugenics.

A change to the US psychiatric landscape came with Adolf Meyer. Meyer brought Kraepelinian ideas of two major classifications of illness to American psychiatry when he left Europe in the late 1800s. He was professor of psychiatry at Johns Hopkins University from 1910-1941 and, despite being the most celebrated figure in American psychiatry of his era, he did applaud 'curative' attempts such as pulling out patients' teeth and removing large bowels as late as the 1930s. He was later to abandon Kraepelin's early ideas of degeneration (as Kraepelin was to do himself) and espouse psychoanalysis which was to take the US on its own psychiatric journey (Double, 2005.) As Shorter (1997, p. 112) notes: "by the 1940s, [Meyer] would be calling schizophrenia 'psychogenic' and urging psychotherapy as the treatment of choice." For psychoanalysts working in psychiatry, unconscious conflict over past events, probably sexual, became the cause of mental distress, not the brain anymore, and cures involved analysis sessions in an office setting (Double, 2005; Hale, 1995.) Psychoanalysis, like the earlier invention of nerves as a disorder of the upper classes, offered both patient and psychiatrist a way out of the asylum (Read, 2004) and into the office (or spa with its long term rest cures, massage, diet regimens and other treatments.)

Psychoanalytic treatment in the twentieth century, like the nineteenth century intervention on nerves, also heralded hope in the face of the hegemony of the biological model (Double, 2005) that had been gripped with the idea of hereditary degeneration and made the populace terrified of the asylum and the psychiatrist (Hale, 1995.) As biological bases for illness, and accompanying medication successes, began to be discovered and proliferate in the twentieth century, psychoanalysis lost favour, but its brief heyday in psychiatry was a colourful one and its impact on Western popular consciousness has been profound (Hale, 1995; Micale & Porter, 1994.) Nevertheless deep analytical work was only

briefly the main preserve of psychiatrists, being absorbed into and diminished within the discipline as more cognitive behavioural techniques and less formal psychotherapy (such as Rogerian client-centred counselling) came to the fore (Pilgrim & Rogers, 1999.) Where psychoanalysis flourished longest was the US and this in turn spawned, in US popular culture, a therapy revolution of self-helpism and New Ageism in the latter part of the twentieth century (Heelas, 1996; Kemp, 2004; Kemp & James, 2007) that has come to influence the rest of the Western World.

Rogerian counselling principles – a client-centred approach in which the client's viewpoint or 'truth' is central – echo back to the attempts of early asylum reformers to engage in the narratives of their patients (Shorter, 1997.) So do cognitive behavioural therapeutic techniques that echo the attempts to provide self-efficacy and structure for asylum inpatients during the height of the curative experiment in asylums in earlier centuries. What must be remembered, however, is that counselling of the Rogerian kind was largely utilized by the unhappy citizens of society not the extremely psychiatrically unwell. However, the 'self as ultimate healer' Rogerian notion did find its way into a twentieth century psychiatry that was influenced by psychoanalysis, particularly in the US, and was also looking back to Romantic ideals of the nineteenth century.

Today talk therapy has its place, though perhaps not to such a degree as clients would like (Micale & Porter, 1994; Pilgrim & Rogers, 1999.) Long-term psychoanalysis can rarely be found in psychiatry today, except in some pockets of psychiatry in the US, but it did wound biological psychiatry for a while. Certainly, the "secularised confessional in modern society" (Pilgrim & Rogers, 1999, p. 111; Foucault, 1981; Rose, 1999) and individualistic preoccupation with the self (Rose, 1999) has, in current times, led widely to voluntary patient relationships with psychiatrists. Such relationships aim to "promote subjectivity" (Pilgrim & Rogers, 1991, p. 111) and, through long-term office-based treatment, regulate normalcy, rather than repressing subjectivity through the behaviourist treatments and containment

model of the custodial systems of the past (Miller & Rose, 1997, 2008; Pilgrim & Rogers, 1999; Rose, 1999.)

This particular literature is relevant to the present study because it shows the entry of psychotherapy and counselling to the field of psychiatric illness treatment. The office-based environment becomes a legitimate site for the treatment of major classifications of mental illness as well as the asylum/psychiatric hospital. A more person-centred approach enters the field and the beginning of an approach based on the reality of the person experiencing the mental distress begins to challenge the authority of the psychiatrist. Other professions who do not prescribe medical treatments begin to operate therapeutically in the field of mental distress, for example psychoanalysis. The idea that mental distress can be cured by healing the deep seated psychological mind-based problems of the mentally distressed becomes prevalent for a time and this idea challenges brain-based notions of treatment due to abnormal brain function. This literature informs how the participants have internalised these quite different approaches to what mental distress is and how it can be treated.

2.2.5 *The twentieth century*: The Diagnostic and Statistical Manual of Mental Disorders

When biological psychiatry made a come-back in the twentieth century, it did so with vigour in order to protect its 'market share' of the maladjusted and miserable in society. It did this because, as Shorter (1997, p. 292) says, by this point, "features of the human condition represented billable psychiatric illnesses."¹⁶ The issue of commercial interest entered into psychiatry due to the increase in medications produced by pharmaceutical companies to treat illnesses that previously only been treated with physical restraint, surgical procedures and isolation.

¹⁶ Today, pharmaceutical companies have arguably become the drivers behind the explosion in diagnoses that now make up the once clear-cut and economical *Diagnostic and Statistical Manual of Mental Disorders*.

The impressive quality of *The Diagnostic and Statistical Manual of Mental Disorders* (DSM) for psychiatry as a profession is that it provided psychiatrists with an authoritative tool. They sought to exercise a “special knowledge” (Pilgrim & Rogers, 1999, p. 101) that might bring them into line with other medical professionals. *The Diagnostic and Statistical Manual of Mental Disorders* lent them ammunition to achieve this. It is short sighted to say that the history of our arrival at psychiatric classifications is the same as a history of psychiatry (Kendell, 1975), but the role of *The Diagnostic and Statistical Manual of Mental Disorders* in modern psychiatry is an impressive one. The history of psychiatry is also a history of containment and attempted cure. Prescribing medication and other treatments such as electro-convulsive therapy offers psychiatry curative opportunities that echo back to Enlightenment impulses (Pilgrim & Rogers, 1999.)

As has been noted above, present-day psychiatry leans heavily on diagnosis using *The Diagnostic and Statistical Manual of Mental Disorders* which was first published in 1952 after a number of other attempts such as the *Statistical Manual for the Use of Institutions for the Insane* (US, 1918) and the *Statistical Classified Nomenclature of Disease* with its psychiatric section (US, 1933) (Shorter, 1997). Perhaps the heavy reliance on the *The Diagnostic and Statistical Manual of Mental Disorders* today is based on diagnosis being so messy and argued over in the past to the point that the actual existence of psychiatric illness has been questioned (Pickering, 2003.)

We should bear in mind, however, that the first *Diagnostic and Statistical Manual of Mental Disorders* – *DSM-I* published in 1952 was heavily influenced by psychiatrists who were also psychoanalysts and that the second version, *The Diagnostic and Statistical Manual of Mental Disorders* – *DSM-II* of 1968, had 60 percent of its input from analysts and their sympathizers (hence the Freudian ‘disorder’ of hysteria being present.) So, even though the impulse to diagnose goes against psychoanalytical principles and is driven by an impulse towards classification, the dominant tool of diagnosis today was formed partly out of the ideas of the field of psychoanalysis (Mayes & Horovitz, 2005; Micale & Porter, 1994;

Shorter, 1997.) This made *The Diagnostic and Statistical Manual of Mental Disorders* light on description of the disorders, something which Robert Spitzer would change with *The Diagnostic and Statistical Manual of Mental Disorders – DSM-III* (Double, 2005.) Spitzer was part of the drafting committee and his instincts were Kraepelinian in terms of wanting to be precise in diagnosis, even though, unlike Kraepelin, he, and a few others like him in the late 1960s and the 1970s in the US, was interested in brain chemistry and research into psychiatric illness's basis in brain biology (Double, 2005; Shorter, 1997.)

A push for “rigorous criteria for making diagnoses” (Shorter, 1997, p. 300) began that would end in “fixed conditions the patient had to meet” (Shorter, 1997, p. 301.) Others who were pushing for strict symptomological criteria were the US insurance companies, termed by Mosher, Gosden and Beder (2004, p. 121) as “the fox watching the chicken coop,” that wanted clear diagnoses and prognoses if they were going to pay for long-term treatment. Such companies were clearly against paying for long-term analysis for an insured person with mental illness, especially when an insurance claim was based on theories such as the Oedipus complex. They wanted clear cut classifications that the insured had to fit (Gupta, 1993; Mayes & Horovitz, 2005.) Mosher, Gosden and Beder (2004, p. 118) describe this as “the social construction of illness ... being replaced by the corporate construction of disease.”

For *The Diagnostic and Statistical Manual of Mental Disorders – DSM-III* (1980), of which Spitzer was the American Psychiatric Association taskforce chair, Kraepelinian approaches, rather than Freudian ones, informed the revision (Double, 2005; Shorter, 1997.) Homosexuality was removed as a psychiatric condition (Bayer, 1981) and rigorous ‘scientific’ research-based symptomology was outlined in great detail for each disorder, making *The Diagnostic and Statistical Manual of Mental Disorders – DSM-III* over 300 pages longer than *The Diagnostic and Statistical Manual of Mental Disorders – DSM-II* (Shorter, 1997.) The 1987 revision, *The Diagnostic and Statistical Manual of Mental Disorders – DSM-III-R*, was translated into 20 or more languages (Shorter, 1997), fairly definitively overturning the anti-

psychiatry (pro-analysis/counselling) movement within formal mental health service provision. Oppositional voices did carry Thomas Szasz (1961, 1970) and R.D. Laing's (Laing, 1960; Laing & Esterson, 1964) anti-psychiatry message (Breggin, 1991; Klerman, 1987), and in the mental health consumer movement in the West an anti-medication discourse began to be put forward in the early 1980s and persisted into the mid 1990s (Goslyn, 1997; Pilgrim & Rogers, 1999.) One problem that must be acknowledged, however, is that the increasing length of subsequent revisions of *The Diagnostic and Statistical Manual of Mental Disorders* was partly because symptomologies of disorders were being added. Disorders were being not only withdrawn due to various pressure groups such as feminists and gay activists (Bayer, 1981; Gupta, 1993) but also 'invented' or discovered by others such as veteran's associations, with post traumatic stress disorder entering *The Diagnostic and Statistical Manual of Mental Disorders* in 1980 (Pilgrim & Rogers, 1999.) The following table shows the increase in the number of disorders classified by *The Diagnostic and Statistical Manual of Mental Disorders* with each revised edition from 1952 through to 2000:

Table 2 - The proliferation of disorders in each subsequent edition of the Diagnostic and Statistical Manual of Mental Disorders from 1952 to 2000

DSM-I	1952	106 disorders
DSM-II	1968	182 disorders
DSM-III	1980	265 disorders (homosexuality removed; PTSD added)
DSM-III-R	1987	292 disorders
DSM-IV	1994	297 disorders (neurosis and involuntal melancholia ¹⁷ dropped)
DSM-IV TR	2000	(text revision)

(Mayes & Horowitz, 2005)

¹⁷ These were specifically female diseases relating to having a womb and problems that can originate in it, in the case of hysteria, and going through menopause and grieving the end of childbearing years in the case of involuntal melancholia (Dowling, 1997.)

The Diagnostic and Statistical Manual of Mental Disorders is not well thought of in all quarters (Mayes & Horowitz, 2005; Shrag, 1978.) Menninger, a prominent psychiatrist, has called *The Diagnostic and Statistical Manual of Mental Disorders* “sheer verbal Mickey Mouse” (Menninger, 1969.) Social politics have continued to be involved in the making of psychiatric diagnosis. Shorter (1997) makes it clear that social politics have continued to drive diagnostic categories rather than scientific research, despite psychiatry’s medical and scientific image. As Shorter notes testily:

Given such antics, it would be difficult to take seriously any official psychiatric pronouncement about problems surrounding sexual orientation, the psychiatry of stress, or women and the menses. These matters could all apparently be pathologized or depathologized at the will of the majority, or following campaigns of insistent pressure groups. (1997, p. 305)

Despite this, diagnosis and medication are what make psychiatry different from psychology, the plethora of psychotherapies or psychiatric social work. Certainly, psychiatry has been under threat from all of these as a profession during the twentieth century. Nevertheless, diagnosis and drug prescription (Mosher, Gosden & Beder, 2004) give psychiatry authority over other disciplines as a science (Micale & Porter, 1994; Pilgrim & Rogers, 1999; Turner, 1987.) Shorter (1997, p. 327) notes that many studies have found “neurochem” and “neurochat” combined are the “optimum form of care.” This is what psychiatry with its mix of talk therapy and diagnosis and prescription of therapeutic interventions offers - something that psychology of the mind alone and neurology of the brain alone cannot achieve.

This section is relevant to the present study because it shows how the power of *The Diagnostic and Statistical Manual* as the authoritative tool in psychiatry developed. This pins psychiatric diagnosis since then to the decision-making of the American Psychiatric Association which produces the manual. This section also shows the way in which social movements can influence diagnosis and challenge psychiatry’s viewpoint of what constitutes psychiatric illness. In a sense this section demonstrates a shoring-up of power in diagnosis and medical treatment by psychiatry while also indicating that minority groups might be wrongly ‘othered’ as psychiatrically ill due to their ‘othering’ in society as a minority group (for

example homosexuals.) This section shows how crucial a social-constructionist view of 'reality' and 'society' is and can help to explain the ways in which the women in the present study negotiate with the diagnoses they have been given, all of which by the time of the present study have been made using *The Diagnostic and Statistical Manual IV* and *The Diagnostic and Statistical Manual IV-TR*.

2.2.6 *The twentieth century: labelling as a sociological act*

It should be noted that diagnosis, combined with the growing variety of medications on the market (Mosher, Gosden & Beder, 2004; Pilgrim & Rogers, 1999), has become a powerful thing,¹⁸ since treatments can be radically different depending on what one's diagnosis is (Gupta, 1993; Shorter, 1997; Turner, 1987.) A person with psychiatric difficulties therefore can have different diagnoses over time based on the decades in which they are assessed by various psychiatrists, the version of *The Diagnostic and Statistical Manual of Mental Disorders* used, the country from which the psychiatrist originates, and even the countries in which they are diagnosed. They are also influenced by the "proto-professionalised" lay people (Pilgrim & Rogers, 1999, p. 106) in their lives, such as family and friends, who seek to ascribe psychiatric illness labels to them in their pre-patient phase before psychiatric diagnosis (Goffman, 1961.) This has meant that 'labelling' has sometimes been a boon for the person suffering from mental distress, giving them meaning and a therapeutic pathway. For others it has been a scourge that makes them feel toyed with and experimented upon as family members impart their perceived wisdom on what ails them and then one psychiatrist after another has changed their diagnosis and therefore their treatment regimen (Erikson, 1994; Lemert, 1967; Pilgrim & Rogers, 1999; Turner, 1987.)

From a critical social science approach, psychiatric illness can be explored theoretically as a mechanism by which people are viewed as having behaviourally broken a

¹⁸ Psychiatric diagnosis's inexactitude as a scientific predictive tool was most famously highlighted by Rosenham's 1970s study in which pseudopatients complaining of psychotic symptoms were admitted to hospital, retained and treated despite them stopping reporting any symptoms from the point of hospitalisation. They were not identified as pseudopatients by staff but some fellow patients did identify them as not being truly unwell (Gupta, 1993.)

social contract with the state and its other citizens (Turner, 1982), as well as a mechanism by which individuals become disenfranchised from the state through the erosion of their citizenship through what Goffman, in *Asylums*, called 'role dispossession' - bringing in discrimination, access and policy issues through what Goffman called 'extrusion' from 'normal' society (Burns, 1992; Goffman, 1961.) This dislocation can be posited as a basis for stasis, hopelessness, lack of awareness of agency, and institutionalised behaviour and for this reason may be an important focus for a study such as the present research.

'Normalcy' is a fictive category assuming the dominance and sole validity of the mainstream and making the 'other' non-valid. Otherness can become part of one's identity since our reference to ourselves in response to and relationship to others is what forms our identity. This may lead to 'anomie'¹⁹ and 'alienation' (Durkheim, 1964) due to the disturbance caused as one attempts to assimilate otherness and rejection into one's identity formation. Simone de Beauvoir sees "otherness [as] a fundamental category of human thought" (de Beauvoir, 1993, p. 16) and Ussher (Ussher, 1991, p. 14) feels that "madness ... as a category for our pain ... marks as the other." "Oppression of the other" to Ussher's mind (1991, p. 299) "is built into the fabric of our society ... powerlessness is one of the routes to madness." Certainly, as Durkheim's work taught us, anomie can lead to suicidality and despair (Durkheim, 1951; Giddens, 1972; Gupta, 1993.) The attribution of an illness to someone, according to Sedgewick (1982) always proceeds from a gap between behaviour or affect and some social norm. In some theories of deviancy, psychiatric illness has been accused of not existing at all, being seen as an attributive tool to label the socially deviant and thereby be able to legitimise force over them (Luhmann, 2000.)

Functional sociologists see deviance and labelling as necessary for the maintenance of order in society through the imposition of rules, roles and rituals to contain and reform those who abandon socially sanctioned behaviour (Gupta, 1993; Turner, 1987.) Roles theory

¹⁹ Anomie was perceived of by Durkheim as a state in which the individual feels that, due the circumstances they find themselves in, they are irreconcilably out of step with the larger social rules which govern society. According to Durkheim's view this can lead to despair and suicidal ideation.

sees that the individual in his time plays many parts, as Shakespeare himself put it (Nisbet, 1970.) A person is inseparable from the roles they play, as pupil, teacher, mother, tourist, or person with a diagnosis of psychiatric illness. Acceptance of hegemonically prescribed roles is an option for all individuals but some contest these roles and, in different eras, there has been more or less contestation in terms of the role of mental patient. There is a group agreement through negotiation of symbols and roles to act various parts in society, and various individuals flourish in these roles while others suffer depending on the power and agency such roles give them and the status and sense-making that can be achieved through them.

Lemert (1967) considered there to be primary deviance (the rule breaking that attracts attention and labelling) and secondary deviance (the behaviour which is produced in an individual as they process the labelling which has been done to them). Erikson identified that 'mad' people go through a ceremony to become psychiatrically ill: they are identified as irrational and unable to function; they come under the scrutiny of the authorities; they are taken to an official place suitable for irrational peoples such as a psychiatric hospital or police station; they are treated, largely with chemicals; and finally they are put back into general society, perhaps to begin the whole circular ceremony again (Erikson, 1994.) In essence, mentally distressed people must be labelled as 'psychiatrically ill' in order to be 'treated' or controlled/changed (Turner, 1987) and labelling theory is based not upon ontological deviant realities but upon the workings of the powerful to control the violators of social norms (Scheff, 1999.)

Labelling theory has been used since the 1950s in the work of Lemert, Becker and Matza (Meighan, 1981). It developed largely out of work on deviance and criminology and looked at the transactional aspects of the 'deviant' person and others in society (Gupta, 1993.) Schur in *Labelling Deviant Behaviour* in 1971 specifically used an interactionist approach to look at the labelling processes involved in psychiatric diagnosis (Lemon, 2004; Schur, 1971) looking at collective rule-making, interpersonal relations between the

professional and the client, and the way in which organisations process psychiatrically labelled people. As more understanding and better treatment develop, certain psychiatric illnesses such as anxiety and depression are removed from the realm of deviance since individuals experiencing these disorders are able to exhibit other traits of viable citizenship, for example the ability to remain at work. The sufferer of these disorders is often able still to operate within the paradigmatic requirements of society – valuing work, competence and cleanliness/order and exhibiting coherent speech and a sense of self as social unit. It may be for this reason that such individuals ‘cope’ with the labelling of having a psychiatric illness (since the label does not connote deviance) while others do not cope because the label they receive denotes to them a dehumanising, outcast status.

What is key to any examination of labelling is to look at the assumptions lying behind the labellers and not just at the social interactions of the labelled (Meighan, 1981.)²⁰ If the labeller sees that cultural norms are being violated in a way that makes the individual act in such a way as to threaten the wider group, then the labelling that is meted out will reflect a strong indictment of deviance and be tantamount to an edict allowing all future ‘treatment’ of the individual to be based on subduing the aberrant behaviour of the person (Nisbet, 1970.) Labelling can be seen as the precursor to what Durkheim (Cole, 1979; Durkheim, 1951) saw as the punitive or rehabilitative actions by the group contributing to the adjustment of the individual – often through a reduction in citizenship rights (Gupta, 1993; Turner, 1987) – so that the individual ceases to behave in an aberrant way or at least their ability to affect society in an aberrant way is curtailed. Once the symbol ‘psychiatric illness’ is agreed upon by others as belonging to one of their group, then a raft of actions can be legitimised with regard to that individual by the group, even against the individual’s will. Such actions with regard to the ‘psychiatrically ill’ can be incarceration, restriction of liberty,

²⁰ A core element of labelling theory is the critical belief in the ‘self fulfilling prophecy,’ ie, labelling leading to behaviour congruent with the label even if the label is wrong ascribed – for example labeling of children as not academic or ‘stupid’ will lead to them not being successful at school. In terms of psychiatric illness, some labels are frequently abandoned for others as more is learned about the individual’s symptoms and/or the rules of diagnosis change with the ongoing development of the *Diagnostic and Statistical Manual*. Whether a diagnostic category ascribed to an individual leads to that behaviour when it was previously not present has not been investigated. However, the behaviour of the medical profession with regard to following a course of treatment based on a diagnosis even when no ‘deviant’ behaviour is being exhibited has been documented most famously by Goffman (1961.)

medication/treatment, rehabilitation and surveillance. The sociology of medicine no longer uses labelling theory as “a dominant paradigm” (Turner, 1987, p. 75) but it nevertheless serves as a useful tool in any theoretical analysis of psychiatric illness creation and diagnosis. Labelling still has power in society and for this reason it has symbolic power in the mind of the individual being labelled.

Symbolic power must not be underestimated when it comes to psychiatric illness. Psychiatric illness, like gender (Felski, 1991), in any study that is sociological rather than merely medical, must be viewed as a symbolic as well as a medical phenomenon. ‘Psychiatric illness’ as a human category changes its symbolic meaning over time and serves to legitimise certain behaviours and beliefs and to silence others. In Aotearoa/New Zealand it must also be viewed in relation to cultural relativity (Becker, 1971) for what is a biochemical illness to P•keh• can be a spiritual sickness to M•ori. Nevertheless, what both biochemical illness and spiritual sickness seem to have in common is an inability to obey “ceremonial rules of social intercourse” (Goffman, 1956, p. 497) and to project to oneself and to the world “a sustainable self” (Becker, 1971, p. 138.)²¹

Psychiatric diagnosis has been accused of being gender unaware and/or hostile to women (Boyle, 1994, 1997; Caplan *et al*, 1992; Micale & Porter, 1994; Ussher, 1991.) As Taussig notes (1992, p. 83), “signs and symptoms of disease are not ‘things-in-themselves’; are not only biological and physical, but are also signs of social relations designed as natural things, concealing their roots in human reciprocity.” Politically and socially, women are encouraged to have multiple roles in relation to the family or community, but psychiatrically they are professionally assessed as individuals based on the traits of behavior and perception that they bring to the diagnostic interview.

‘Madness’, according to Ussher (1992, p. 13) “position[s] ‘woman’ within society, within discourse ... madness acts as a signifier which positions women as ill, as outside, as

²¹ Events such as job downsizing and workplace restructuring due to socio-economic changes, such as the neo-liberalisation of society, can lead to a struggle to project to oneself or the outside world a sustainable self and this has led to both mental and physical illness (Chang, 2000).

pathological.” It might be said that psychiatric diagnosis was unfairly gender aware when it ascribed hysteria to women – the name of the condition coming from the Greek word for uterus (Turner, 1987.) R.D. Laing (2001) would have seen women’s distress at her social condition as a sane response to an insane world. Similarly, a number of conditions – eg, anorexia scholastica – were ascribed to girls seen to have too zealous career ambitions (Astbury, 1996.) Radical thinkers have suggested doing away with gender-biased diagnoses like agoraphobia and depression and using instead terminology which denotes less of a psychiatric and more of a cultural construction (Gelfond, 1991; Hallam, 1983; Wiener, 1989) since, in the case of agoraphobia, the meaning of home and the desire to leave it or not is very different for women than for men. Furthermore, the diagnosis of depression puts the onus on the individual to cope, with the help of treatment, rather than putting the onus on the group to look at the psycho-social factors which might be underpinning the behaviour and beliefs which lead psychiatrists towards the diagnosis of depression (Woollett & Phoenix, 1997.) The severe mental disorders of schizophrenia and bipolar disorder show no specific gender markers but gender does affect the course of such disorders, social adjustment from them and long term outcomes.

Certainly, women have been fainting with the vapours, weeping neurotically and vampirically seeking lesbian conquests in literature and film for decades. Lesbianism was considered a psychiatric illness for a large part of the twentieth century in psychiatry. As a violation of social norms, it was classified as an illness in the *Diagnostic and Statistical Manual* of the American Psychiatric Association for many years. Queen Victoria kept it from being regarded as a psychiatric illness in the United Kingdom, however. Women have been pathologised for something which represents an individual weakness in the case of 1950s housewife neurosis (in what was colloquially termed ‘the valium era’ due to the main use of that benzodiazepine to treat women with the diagnosis) and a social transgression in the case of lesbianism (Gupta, 1993) rather than reasonable responses to powerlessness, oppression or minority sexual orientation (Appignanesi, 2008.) Psychiatric diagnosis, with its

origins in the West and its authority now lying with the American Psychiatric Association in the US, relies on a paradigm of individualism that is quintessentially Western and takes little account of the social conditions, power and status of anyone who is not male, white, able-bodied or heterosexual. Devalued or underpaid work, unpaid care work, housework, children, relationships with men as the dominant gender and exposure to abuse and violence are all seen as contributing to women's risk of developing mental distress (Gove & Geerken, 1977; Gupta, 1993; Williams, 2005.) To Williams (2005, p. 161), being "a good woman" is tantamount to "minimizing, normalizing and coping with disappointment and distress" and leads to mental distress. Bernardez's (1996), Harris's (1998) and Watson, Scott and Ragalsky's (1996) studies have found that women gain significant support in their mental distress from other women in the same situation and that this leads to less of an individualized pathological view of their predicament and more of an awareness of how socially and cultural circumscribed their lives and problems are.

This literature is relevant to the present study because it clearly shows that there are complex issues when looking at issues around psychiatric illness. Examining the historical background of psychiatric illness shows how an 'othering' of the psychiatrically ill has developed and has, as a consequence, produced rejection of the psychiatrically ill in the community, leading to stigma and discrimination. The idea of 'othering' is useful to consider when exploring the experiences of the women in the present study. Also, labelling is shown to be a powerful symbolic tool and may operate in the lives of the women in the present study. The problematic role of women in society is shown to be an important consideration in terms of the cultural circumscription of the experience of women with psychiatric illness. The disempowerment of women is shown to clearly impact upon their experience of the psychiatric system.

2.3 Mental distress and psychiatric illness in Aotearoa/New Zealand

2.3.1 The general Aotearoa/New Zealand population

Since the late 1970s in Aotearoa/New Zealand, the admission rate to hospital for psychiatric illness has been less for women than for men. Married women were more likely to be admitted and single men more likely to be admitted up until 1987, when unmarried and married women were proportionally equal in terms of admission statistics. Māori women were more likely to be admitted for psychotic disorders than Pākehā women during this period (New Zealand Department of Statistics, 1990.) Nevertheless, in all demographic groups – taking account of age, marital status, age of first child, employment status, job classification, socio-economic status, and ethnicity – women showed higher levels of ‘reported’ psychiatric illness than men (New Zealand Department of Statistics, 1990).

In 2008, the World Health Organisation estimated that three people in every hundred experience a psychotic episode or ongoing psychosis in their lifetime (www.mindnz.co.nz). The National Institute of Mental Health in the United States has given an estimate that one in every four or five Americans have an episode of psychiatric illness at some point in their life (Gupta, 1993). The estimates for Aotearoa/New Zealand are that 47 percent of New Zealanders experience a psychiatric illness or substance abuse disorder in their lifetime (Peterson, Barnes & Duncan, 2008) and one in five New Zealanders experiences some kind of psychiatric illness in any given year (Browne, Wells & Scotts, 2006). Also it is estimated that at a minimum 10 percent of GP visits are for mental health problems, though this figure could be as high as 30 percent (Browne, Wells & Scotts, 2006.) Five percent of all GP visits to do with mental distress are referred to secondary services. Roughly one in every hundred New Zealanders experiences bipolar disorder and similarly one in every hundred experiences schizophrenia. The World Health Organisation estimated that roughly 67,000 people are disabled by psychiatric illness in Aotearoa/New Zealand in 2008

(www.mindnz.co.nz). Interestingly, women are over-represented in certain categories²² of psychiatric illness in a similar way that M•ori and Pasifika people are over-represented in hospitalization figures (Cosgrove, 2000).

Since 1993, exactly a century after women gained the vote in Aotearoa/New Zealand – a world ‘first’ – (Grimshaw, 1975), there has been a *Human Rights Act* in Aotearoa/New Zealand which makes it unlawful for a person to discriminate upon someone with a psychiatric illness. Under the Act, employers are required to make reasonable accommodations (for example flexible working hours) to people with disabilities, including people with psychiatric illness. The only requirement to disclose a psychiatric illness to an employer is if it would make undertaking the tasks of the work role a danger to others (eg, flying an aeroplane while on a sedating medication) or difficult to perform (eg, working in retail when one has a social phobia) (Like Minds Like Mine Canterbury Employment Book Project, 2006.)

Since the 1980s the diminishing role of the hospital setting in treatment and huge advances in medication efficacy, plus large scale abandonment of electroconvulsive therapy (Haines, 1987) and lobotomies, have changed the landscape of psychiatric illness treatment in society. In Aotearoa/New Zealand, the accounts of people in hospitals in the 1970s differ widely from those in hospitals in the 1990s (Goodwin, n.d.). Many of the old psychiatric services, so vilified in civil suits for systematic abuse of patients in their care in the 1970s and 1980s, have been closed, for example Cherry Farm (Dunedin), Lake Alice (Rangitikei), and Kingseat (Auckland). Some were renamed before closure or still operate under a very different service provision style, for example Kingseat became Carrington which then closed and Sunnyside in Christchurch became Hillmorton which still operates. Since the 1980s new medications such as clozapine and quetiapine have produced large scale symptom

²² The Australian Bureau of Statistics in 1997 undertook a survey which showed that 12 percent of women compared to 7.1 percent of men are diagnosed as having anxiety disorders at any one time in a twelve month period and 7.4 percent of women are diagnosed as having mood disorders such as depression compared to 4.2 per cent of men (Miller, 2000, p. 3). The lifetime prevalence of depressive episodes for women was given as almost twice that of men – 16.3 percent compared to 8.8 percent. Women also had more incidences of a diagnosis of schizophrenia and bipolar disorder, whereas men had more incidences of diagnosis of a drug or alcohol addiction (Miller, 2000, p. 4).

reduction to the point where many individuals with psychotic illness may not even have experienced a hospital setting. Many have been freed from the experience of life in an institution (or in supported accommodation in the community), and have been given some employment opportunities, due to the increased efficacy of pharmacological interventions (Bond & Meyer, 1999.)

Like other Western countries, Aotearoa/New Zealand has been subject to the deinstitutionalization of its psychiatric services in the latter part of the twentieth century (Neff, 2006; Tse, Doughty & Bristol, 2004.) Mayes and Horovitz note that “the term *deinstitutionalization* refers to the release of many long-term psychiatric patients from state-run mental health hospitals, which housed people with mental disorders for long periods of time” (2005, p. 254.) There was a pervasive view among psychiatric administrators in the Western world, that “the mental hospital itself could produce deleterious psychotic symptoms” (Neff, 2006, p. 232.) This view is largely promulgated by the writings of Laing and Szasz (Laing, 2001; Szasz, 1961, 1963, 1997) who both strongly condemned the psychiatric institution and saw it as an abusive environment. New medications and social change led to deinstitutionalisation of psychiatric services to community care (Brown, 1985; Gronfein, 1985; Grob, 1995; Mayes & Horovitz, 2005.) Nevertheless, administratively constructed communities (eg, hospitals, supported accommodation and life skill programmes) have a major role in the lives of people with experience of living with psychiatric illness in the West (Neff, 2006.) It should be noted that, as in the rest of the contemporary Western world, it is difficult in Aotearoa/New Zealand to gain access to inpatient psychiatric services due to funding constraints, and some people are now deemed to be denied care when they need it (Luhmann, 2000). It is quite a reversal of the era of enforced inpatient treatment.

In Aotearoa/New Zealand, a recovery-based approach to treating psychiatric illness has been promoted by the Mental Health Commission (Tse, Doughty & Bristol, 2004) and a resiliency-development approach based on promoting individual’s strengths has been built on top of this. Recovery/resilience-development approaches focus on being able to survive

and thrive whether one's illness is present or not at any given time. Also, Aotearoa/New Zealand uniquely, in the mid 1990s, was influenced by the *Inquiry under Section 47 of the Health and Disability Service Act 1993 in Respect of Certain Mental Health Services: Report of the ministerial inquiry to the Minister of Health Hon Jenny Shipley*, which has come to be termed the 'Mason Report' (Mason, Johnston & Crowe, 1996.) Its publication in 1996, and adoption through policy changes, led to increased funding for mental health services and a focus on workforce development that has seen Aotearoa/New Zealand become unique in actively seeking people with experience of psychiatric illness to work in its mental health workforce as part of its 'by and for' service development policy. The 'Mason Report' provided the impetus for an anti-discrimination campaign (later renamed a 'project') called *Like Minds, Like Mine*. The *Like Minds, Like Mine* project to counter stigma and discrimination associated with psychiatric illness (best known for its 'Know me before you judge me' TV advertisements) was established in 1997. .. *Like Minds, Like Mine* is a national, government funded programme with the purpose of reducing the stigma and discrimination associated with psychiatric illness. Led by the Ministry of Health, the programme is delivered by national and regional organizations, such as the Mental Health Foundation of New Zealand. It combines nationwide strategies and media work with community action, consumer workforce development and mental health workforce development. There is currently a national *Like Minds* plan in operation covering the period 2007-2013. *Like Minds* was inspired by the Australian anti-discrimination campaign of the early 1990s.

Australia's *beyondblue* depression awareness campaign has inspired the *Out of the Blue* Aotearoa/New Zealand depression awareness campaign in the new millennium. *beyondblue* is a bipartisan initiative of the Australian, state and territory governments. A national, independent, not-for-profit organisation was set up to address depression, anxiety and related substance misuse disorders in Australia. Its main aim is to raise community awareness of depression and reduce stigma for people experiencing depression. Work is undertaken in health services, workplaces, secondary and tertiary educational facilities and

community organizations. *Out of the Blue*, run by the Mental Health Foundation of New Zealand, is a depression awareness campaign aimed at showing that recovery from depression is possible. The Mental Health Foundation on its website (www.mentalhealth.org.nz) notes that in Aotearoa/New Zealand, one in five women will experience depression at some point in their lives. *Out of the Blue* uses a website, referral to support websites and phone lines, real stories and celebrity endorsement to deliver its message.

Both Australia and New Zealand's approaches to these campaigns are underpinned by a commitment to the Ottawa Charter (WHO, 1986) which provides five areas for action in regard to health promotion, under which mental health promotion sits. These five areas are: building healthy public policy; creating supportive environments, strengthening community action, developing personal skills and reorienting health services (Field, Highet & Robinson, 2002.) Certainly the 'Mason Report's' call for a reorientation of health services (Mason, Johnston & Crowe, 1996) and changes in service-user accounts over time (Goodwin, n.d.) may be directly due to this shift in organizational thinking.

Funded by the *Like Minds, Like Mine* project was the study that resulted in the report *Fighting Shadows: Self-Stigma and mental illness: Whawhai Atu te Whakam• Hihira* (Peterson, Barnes & Duncan, 2008). *Fighting Shadows: Self-Stigma and Mental Illness: Whawhai Atu te Whakam• Hihira* was the report produced by a research project that looked at internalized stigma for 76 people with experience of living with a psychiatric illness. It found that family and friends were perceived by the participants as being the most discriminatory towards them. It also identified unhelpful beliefs about psychiatric illness from the general population as being the cause of much stigma. Its main finding is that negative messages in society around psychiatric illness shape the self-image people have and that this thwarts people from participating fully in society by creating a cycle of internalized stigma. Feelings named in the study were isolation, self-doubt, rejection by family and peers,

and pessimism about prospects of recovery. The term ‘circuit-breakers’ was used to describe what participants saw as ways of countering this stigma. These included greater visibility of people with psychiatric illness in the media and society at large, building support networks with people who have experienced the same illness and stigma, affirming the human rights of people with experience of psychiatric illness, challenging negative stereotypes, and reorienting mental health services to focus on recovery models.

This research echoed the findings of other studies undertaken by Peterson as the principal researcher during and for the *Like Minds, Like Mine* project, particularly *Respect Costs Nothing: A survey of discrimination faced by people with experience of mental illness in Aotearoa New Zealand* and *I Haven’t told Them, They Haven’t Asked: The employment experiences of people with experience of mental illness*. *Respect Costs Nothing* reported the findings from a survey (carried out in 2003 by the Mental Health Foundation) of 785 people with experience of living with a psychiatric illness. The aim of the survey was to help illuminate the nature of any discrimination they might have experienced. The study found that fear of discrimination was “as crippling as discrimination itself” (Peterson, Pere, Sheehan & Surgenor, 2004, p. 7). *I Haven’t Told Them, They Haven’t Asked* is the report of a study of the employment experiences of 22 people with experience of living with psychiatric illness. The study found that job seekers/employees with experience with psychiatric illness frequently face discrimination from both employers and work colleagues. *I Haven’t told Them, They Haven’t Asked* also found that “employment was a positive experience” (Peterson, 2007, p. 6) but problems with on-the-job concentration and the need to stop work due to illness were common.

All three of these studies – *Respect Costs Nothing*, *I Haven’t told Them, They Haven’t Asked* and *Fighting Shadows* – examined their data through a lens heavily influenced by discourses on discrimination. This aligns with the *Like Minds, Like Mine* project’s brief to counter stigma and discrimination associated with psychiatric illness. These pieces of research are useful in that they look particularly at the efficacy of workplace

accommodations for people with experience of psychiatric illness (as well as issues of disclosure and the effectiveness of supported employment.)

This literature is relevant to the present study because it outlines the current socio-cultural context that the women's narratives exist within with regard to psychiatric illness. It shows that women have particular socio-culturally circumscribed experiences and that their thinking will have been influenced by government-funded campaigns as well as the politics of deinstitutionalisation. This section also shows that Aotearoa/New Zealand, while having special characteristics, nevertheless follows the rest of the Western world in its psychiatric illness trends. This means that the present study can reliably draw upon international ideas and models when examining the impact of mental distress upon women in Aotearoa/New Zealand as they negotiate their careers in the very early years of the 21st century.

2.3.2 M•ori

In 2006, when the last of the interviews in this study were undertaken, M•ori made up 14 percent of the Aotearoa/New Zealand population (Baxter, 2008.) M•ori are a more youthful population than non-M•ori and as a population are growing faster than P•keh• (Durie, n.d.) M•ori also bear more significant health problems due to overall lower socio-economic status (Ministry of Health, 2008a.) Up until the 1970s, M•ori were under-represented in psychiatric hospital admissions but by 2004 over half would have a mental health problem at some point in their lives. This particular Indigenous issue, along with the influence of M•ori health models upon the wider population in more recent years, makes Aotearoa/New Zealand different from Europe and the US despite inheriting its psychiatric tradition from the West. Fifty percent of those M•ori surveyed in the *Te Rau Hinengaro – The New Zealand Mental Health Survey* (Ministry of Health, 2008a) had already experienced mental distress and 1 in every 7.5 participants in the *Te Rau Hinengaro* study had had some kind of contact with mental health services in the previous 12 months (Oakley-Browne, Wells & Scott, 2006.) *Te Rau Hinengaro* was a study, undertaken between 2003 and 2004, that used a nationwide

face-to-face household survey of people 16 years and over to gain its data. There were 12,992 participants of whom 2,595 were M•ori and 2,236 Pasifika. Lay interviewers administered a computerized version of the Composite International Diagnostic Interview (the World Health Organization World Mental Health Survey Initiative version.) According to the writers of *Te Rau Hinengaro*, most M•ori felt satisfied or very satisfied with their treatment from mental health services. The study found that psychiatric illness is common in Aotearoa/New Zealand and that many people with a current illness, some of whom were seriously unwell, were not receiving any treatment. In 1998, the Christchurch Health and Development Study – a longitudinal study following a cohort of over 1,000 people born in Christchurch in 1977 – found that, among M•ori 16-18 year olds, depressive disorders occurred in 25 percent and substance use disorders amongst 33.9 percent. 25.9 percent of M•ori females in the study had experienced more than two disorders (Horwood & Fergusson, 1998.) In summary, M•ori are more likely than non-M•ori to experience a Western diagnosis of psychiatric illness at some point during their lives (Ministry of Health, 2008a.)

In Te Ao T•whito (traditional M•ori culture) – pre-European settlement – mental distress and physical illness was treated with the idea of restoring balance to the individual or group. People would diagnose – through the *tohu* (spiritual healer) - *tapu* (eg, the special status of a place being violated) and *makutu* (eg, curses being placed on someone who has transgressed against someone else) as reasons for mental distress. With the influence of Te Ao Hurihuri (literally ‘the turning world’ or change over time, indicating modern times), M•ori have developed their own contemporary models of health and wellbeing, the most well known being Mason Durie’s Whare Tapa Wh• model which describes four dimensions of wellbeing: *te taha wairua* (spiritual health), *te taha hinengaro* (emotional and psychological wellbeing), *te taha wh•nau* (a healthy social environment) and *te taha tinana* (physical health) (Durie, 1994; Kingi and Bray, 2000; Ministry of Health, 2002.) Durie has recently drawn back from the *taha wairua* aspect of this model largely due to P•keh• and *tau*wi lack of understanding of the concept. There is a lack of understanding of

taha wairua's link to cultural identity and the view that poor mental health stems from an insecure identity (Durie, 2003.)

M•ori counsellors today frequently use mauri therapy (bicultural therapy) and Paiheretia (relational therapy) with M•ori clients (Durie, 2003.) M•ori in public health circles also add the perspective of health viewed as te ao turoa (the environment and M•ori stewardship of it) and te reo rangatira (views and beliefs of the people as a focus of identity) (Ministry of Health, 2002.) There is also Te Pae Mahutonga which focuses on the Southern Cross constellation of stars as a model of health. The four points of the compass and two additional pointers symbolise leadership, autonomy and community: te orange (participation in society); toiora (healthy lifestyles); ka manakura (community leadership); wairoa (physical environment; mauriora (cultural identity) and te mana whakahaere (autonomy) (Ministry of Health, 2002.)

Because M•ori have a strong political presence compared to other world Indigenous cultures, health care services in general in Aotearoa/New Zealand have, since the mid-1990s, attempted to acknowledge wh•nau/group identity and adopt group and family wellness models, unlike other more intractable sectors of State stewardship such as the law (Baker, 2000.) This acknowledgement of whanau-based identity in Aotearoa/New Zealand health policy is not reflective of more traditional mental health systems in the United States, Australia and the United Kingdom. Aotearoa/New Zealand has an innovative and more emancipatory approach to mental health service delivery, in particular through its use of mental health community support workers who (unlike social work clinicians who have degree level qualifications and professional registration) walk alongside clients more as a 'buddy' than a clinician (Weil, 2005.) Community support workers can undertake certificate level training (NZQA level 5) but may also have no formal training. Community support workers have been a major community initiative of the Ministry of Health since the mid-1990s and they operate from a recovery/resilience collectivist social model of psychiatric illness, rather than an individualistic medical model (Weil, 2005.) Social models of mental

illness are widely accepted in mainstream psychiatric service provision in Aotearoa/New Zealand, unlike other English speaking countries.

For M•ori, it is possible for clinicians and support workers to operate from the perspective of planning treatment around diagnoses that are traditionally M•ori and do not exist in the *Diagnostic and Statistical Manual* - being based on “the power of the mind and vulnerability to a number of deities” (Durie, n.d., p. 47.) Mental distress for M•ori is part of a wider illness classification called ‘mate atua’ where no external cause can be found for the illness. Throughout Aotearoa/New Zealand, M•ori, and even some P•keh• or Pasifika people (the latter also having their own culturally-based service delivery options) can receive traditional M•ori treatment by M•ori’ services paid for by the State as part of the State’s response to mental and emotional distress in the community. This innovation, funded directly by the Ministry of Health, influences other services to see mental illness treatment in social and cultural terms rather than solely medical terms. The influence of a strong contemporary Indigenous population (with detailed understanding of its traditional view of mental distress) upon mainstream psychiatric service delivery in Aotearoa/New Zealand distinguishes the country from others in the Western World.

M•ori culture operates from the position of identity being a collective rather than individual phenomenon and this has influenced P•keh• culture to adopt social role valourisation models of mental health as well as medical models in general psychiatric service provision. For countries without this strong Indigenous influence, national policy and service provision planning may be more difficult to create with the same innovation in service delivery as has occurred in Aotearoa/New Zealand in the last two decades. Traditional approaches to relieving illnesses have, in the last two decades, clearly been given respect and a valid place in the psychiatric sector in Aotearoa/New Zealand. Today, mental health programmes for M•ori must either incorporate the M•ori perspective into their programme, be ‘by and for M•ori’ in a M•ori setting where tikaka M•ori can be used, or be a specialist

service where *tikāka* M•ori is used as a specialist procedure (Dept of M•ori Studies, Massey University, 1995.)

M•ori mental health concerns are also considered in each of the 'mainstream' mental health promotion models currently used in Aotearoa/New Zealand. These are the population health model (a social, economic and culturally aware model that covers all manner of human needs from shelter to social justice and equity), the community development model (developing health and wellbeing capacity by strengthening various communities to solve their own problems), the primary mental health care model (focussing on enrolled populations and primary health care practitioners – eg, doctors, nurses, social workers), the strengths-building model (focussing on endurance and resourcefulness and not dwelling on symptoms and diagnoses or past hurts), and the recovery model (focussing on an individual's pursuit of wellness and commitment to personal action despite a psychiatric condition) (Ministry of Health, 2002.) While M•ori culture might be said to be based on *geimenschaft* (relationships based on community membership)²³ and P•keh• culture might be said to be an example of *gesellschaft* (relationships based on 'rationally' motivated affiliations), one must be careful not to see M•ori and P•keh• as binary opposites (Walker, 1990.) Nevertheless, these quite different approaches to social relationships and personal development are worth discussing further. Gonzalez-Mena (2003) notes that, according to Triandis (1986), 70 percent of the world's population are collectivists (those whose upbringing helped them to predominantly integrate as children, rather than those who predominantly individuate.) Bicultural children (such as M•ori to a greater and P•keh• to a lesser degree) will be required to integrate both aspects into their self-concept. Gonzalez-Mena also notes that Hofstede (1983) in a study of the business world put English speaking countries colonized by the British Empire at the top of an individuation scale.

²³ Common experience, hardship and resistance in the face of P•keh• stewardship of the land adds to an already collectivist Indigenous culture in Aotearoa/New Zealand. Collectivism has been reinvigorated in the face of oppression and common experience and M•ori have been seeking reparation through the instrument of the Waitangi Tribunal. The tribunal hears iwi claims against the Crown for land and 'mana' stripped from them during colonisation (Bishop & Glynn, 1999.)

Neo-liberalism which arrived in New Zealand in 1984²⁴ (Oakes & von Dadelszen, 2003) with the Roger Douglas's role of Finance Minister in David Lange's Labour cabinet, promotes highly individualised cultural values. The only rights neoliberalism espouses are those of the Smithian²⁵ individual and those of non-interference (Griffin, 2006.) Even the Third Way (a mix of welfarist and neo-liberal policy) watering down of neoliberalism by Helen Clark's Labour Government in the early years of the new millennium promoted the individual, rather than community and society, as can be seen from the 'work-life balance' rhetoric of that time (McManus, 2009.) Citizens were encouraged to develop various personal meanings around work and leisure that were often unrealistic because of the socio-economic and labour market environments in which they find themselves (Meijers, 1998.) Social support for individual failure to thrive in the world of work was eroded as the Aotearoa/New Zealand welfare state experienced a long barrage of reform and corporatisation. Of course, the economic downturn of 2008 and the years immediately following has revisioned neo-liberalism as major financial institutions are 'bailed-out' by the governments they once sought to depose or are themselves made public assets when their 'captains of industry' once sought to make all public assets (such the military, schooling and health) private.

Against this backdrop, civil rights activists have only recently achieved rights for a group who have largely achieved human rights elsewhere in the world decades (the UK and the US) if not centuries (Italy and France) before. Homosexuality was only made legal in Aotearoa/New Zealand in 1986. Even the World Health Organisation had ceased to call homosexuality an illness a decade prior. This reflects the strong social conservatism that has held Aotearoa/New Zealand in its grip until recently. Aotearoa/New Zealand – enduring neo-liberal experiments more drastic than Ronald Reagan's in the United States and Margaret Thatcher's in the United Kingdom – in order to dismantle the once very paternalistic 'Nanny

²⁴ By 1989 the education sector began to be 'reformed'. The Department of Education was divided into a smaller Ministry and several Crown entities including Career Services Rapuara which was an amalgamation of the Transition Education Division of the Department of Education and the Vocational Guidance Service and career information services of the Department of Labour.

²⁵ Adam Smith (1723-1790) was the first major economic thinker to espouse radical notions of liberalism and is considered the founder of free market economics (Smith, 1977.)

State,' has introduced legislation based upon the rights of the individual, not so much enshrining particular groups' rights as criminalising discrimination towards any individual for any reason. The *Homosexual Reform Act* in 1986 and the *Human Rights Act* in 1993 reflect this. Indeed, Aotearoa/New Zealand, through its privacy and anti-discrimination legislation, Health and Disability Commission, Mental Health Commission and Privacy Commission, Ministry of Women's Affairs, Waitangi Tribunal to settle Maori claims against the Crown, and Ministry of M•ori Affairs, now has a stronger rights-based system of governance than many countries that emancipated marginalised people in earlier decades. It could be that because such changes have occurred in the last twenty years they have influenced health and disability sectors, as well as race relations, more radically than similar reforms in other counties in previous decades. It may be that for this reason, despite Aotearoa/New Zealand's neoliberal experiments, the majority of the M•ori population has not been shaken in its collectivist, wh•nau/iwi based values (Bishop & Glynn, 1999) and human services actively seek to be collectivist, non-discriminatory and inclusive of difference at the policy and practice-management level in all services, not just those for M•ori, rather than paying passive 'lip-service' to it..

This literature is relevant to the present study because it indicates the influence that M•ori ideas and models of health may have upon the experience of the women in this study despite their majority P•keh•/tauwiwi status. It will be interesting to discover in what ways, if any, M•ori have shaped the women's experiences as they negotiate psychiatric illness and career issues in 21st century Aotearoa/New Zealand.

2.4 Summary

To conclude, European and British/Commonwealth psychiatry have different traditions and are markedly dissimilar all the way through to the twentieth century (Porter, 1991; Shorter, 1997). America split from the British tradition of psychiatry in the twentieth century and

adopted a more European model of what the therapeutic function of psychiatry should be (Shorter, 1997; Grob, 1991a, 1994). This change was driven by the exodus of psychiatric practitioners from the horrors of Nazi Germany's treatment of the psychiatric ill (Read & Masson, 2004) and the Jews and many other undesirables, and the introduction of psychoanalysis from Europe – a phenomenon that only flourished briefly in Britain but took a hold in America that still endures²⁶. Psychoanalysis developed out of nineteenth century European spa treatment of mental distress and would go on to influence the United States' mental health treatment of both nervous and mood/thought disorder illnesses (Grob, 1991b.) The same could not be said of England and its commonwealth dependents such as Australia and Aotearoa/New Zealand who largely eschewed psychoanalysis. Australia and Aotearoa/New Zealand's asylum history is brief (Miller, 2000) though its psychiatric institutions have managed to enter the Aotearoa/New Zealand imagination as awful places in which to be incarcerated.²⁷ Aotearoa/New Zealand follows Britain in many of its trends (though an interest in 'talk therapy' does show American influences), but the influence of Māori on psychiatric treatment, and the late advent of some civil rights successes and anti-discriminatory legislations in comparison to other Western countries, gives Aotearoa/New Zealand its own characteristics in terms of psychiatric treatment, some of which can be seen to be in line with a social model of psychiatric illness (not just the medical model) at a policy and practice level not seen in the United States, Australia and the United Kingdom.

In terms of women specifically, psychiatric illnesses can be seen to affect women differently from men and some disorders are deemed to be more common in women or exclusive to women, such as postpartum disorders. Also, diagnosis has been used as a punitive tool to control some women historically, as can be seen for lesbian women. In relation to women, the World Health Organisation acknowledges on its mental health website (www.who.int/mental_health/prevention/genderwomen) that:

²⁶ It has entered the popular imagination in America and has been much lampooned by the likes of Woody Allen in numerous films and Robert de Niro in *Analyze This* (1999) and *Analyze That* (2002.)

²⁷ For example, Miller (2000) notes that Seacliff, in which the major New Zealand writer Janet Frame was a resident for almost a decade, entered the headlines in the 1940s when a chaplain exposed the terrible conditions, for example, raw sewage pouring over the grounds from unfixed pipes.

Gender specific risk factors for common mental disorders that disproportionately affect women include gender based violence, socioeconomic disadvantage, low income and income inequality, low or subordinate social status and rank and unremitting responsibility for the care of others.

CHAPTER 3

Career Development

3.1 Introduction

The aim of this section is to furnish the reader with a picture of the kinds of ideas that prevail due to a century of career development theory and research, and then to communicate the specific ideas related to women and people who experience psychiatric illness. Research on career development has largely been undertaken overseas but a sense of the status of career development thinking in Aotearoa/New Zealand will also be provided.

3.2 A brief general history of Western career development ideas

3.2.1 Early twentieth century career theory

Career theory develops out of Western early twentieth century thinking by United States social reformer Frank Parsons. The background to Parson's reforming work rests in the social problems of all countries in the West due to the movement of populations into the cities with industrialization. These problems led to a need for social reform, and the focus on reform of industries, groups and schools ended up resting on the individual. The notion of social progress and self-betterment meant that, rather than lifelong unquestioned static work roles, the concept of 'careers' became the norm. For Parsons the term 'career' incorporated an idea of progression, self direction, work and the intersection of life roles and social environments. To him it covered more than just 'work' or 'jobs'.

Parsons is credited with developing the idea of vocational guidance out of which careers counselling and then counselling emerged. In 1908, he opened the Vocational

Bureau of Boston. Parson's *Choosing a Vocation* was published in 1909 and reprinted in 1967 and 2008. His focus was particularly on school-to-work transition. His work influenced a large area of career development theory (trait and factor) which still is strong in careers work today. Parsons developed a scientific procedure for choosing a vocation by developing awareness of one's needs and aptitudes, and the demands of certain occupations. It is useful in occupational selection which is a core element in careers service work, but also useful for work adjustment issues. Helped by a vocational counsellor, individuals could examine their qualities and study which jobs suited them and the education needed for those jobs. There are many scales and tests developed from this theory which relies upon the notion that career satisfaction occurs when there is the most congruence between an individual's traits and a job's factors. Most focus on traits rather than both.

Roe in the 1950s, Hoppock in the 1960s and Ginzberg in the 1970s developed career development ideas based on Maslow's hierarchy of basic needs: physiological; safety and security; belongingness, social, and love; esteem and self-actualisation. They felt that psychological commitment to an occupation involves congruence between the private self and occupational self-concept. What must be made clear at this point is that the 'individual' upon which most of this research was undertaken was a white middle class American university undergraduate or graduate – the most commonly available participant in psychology research at the university level. It should also be noted that career guidance practice and theory is largely based on the work of people in the United States. In later years, it has diversified but there still remains an underpinning of US-based ideas around careers.

3.2.2 Trait and factor theory

Holland's RAISEC typology (1959) is an example of a theory and model extending the ideas of Parsons. According to Holland we behave according to how we are placed in an

environment and how we are in terms of our personality type. He felt that human beings naturally seek out environments that fit their type. A workplace 'fit' could be said to occur if a person's personality 'type' and work environment were congruent with one another. He developed a typology based on the belief that people and work environments can be assessed as: Realistic, Investigative, Artistic, Social, Enterprising or Conventional (Holland, 1973.) An individual will be a mix of three of these with a weighting for one type more than the others. Holland described the relationship between personality and occupational environment with a hexagonal model where 'common' or expected closely related types were adjacent and types expected to be unrelated were opposite (Holland, 1997.) Inventories to help people determine their 'type' were developed, for example the *Self Directed Search*. Responses to questions about particular jobs and activities provided people with scores that they could collate to discover their three-letter code. This three-letter code corresponded to three-letter codes given to occupations. People could complete the inventory and check their personality type alongside similar job types. While Holland's tools were prevalent in the 1960s, 1970s and 1980s, they were also researched and criticised for gender and socio-political bias (Arnold, 2004.)

Many job allocation tools – both paper-based and computer-based – have Holland's underlying schema as their basis. The hexagon model can be found on the walls of many careers services today²⁸ to explain the relationship between personality and occupational environment. It should be noted that despite its use in research studies, little research has actually been done to verify or refute the principal assumptions upon which Holland's RAISEC typology is based (Sharf, 2002.) Numerous studies have nevertheless been based upon the RAISEC typology (Quimby & DeSantis, 2006.) Examples of research include a study which showed that the Social code is more prevalent in RAISEC testing of African American women than for other women in the US (Russell, 2005). In other research by Betz and others, self-efficacy has been seen as a crucial factor in women's choosing fields which

²⁸ Early on in my study I did see it on the wall of the Christchurch Polytechnic Institute of Technology's career service.

are traditionally male, including Investigative and Realistic career types (Betz & Fitzgerald, 1987; Betz & Hackett, 1983). Quimby and DeSantis (2006) feel that mentoring is another crucial factor in women's career choices, particularly when entering traditionally male domains of work.

Another trait and factor (or person/environment) theory is work adjustment theory, developed by Dawis and Lofquist in the 1970s (Dawis, 1987; Dawis & Lofquist, 1984; Sharf, 2002.) It models the dynamic interaction between individuals and their work environment that both parties act upon to provide a mutually satisfactory correspondence of fit. Withrow (2006) recently used work adjustment theory as the theory to explain how positive levels of correspondence with workplaces could be achieved by women with experience of anorexia nervosa.

Trait and factor theory is relevant to the present study because it demonstrates the way people make basic decisions about career development by assessing their own traits against the factors of a job or workplace. The fact that women tend towards certain RAISEC typologies indicates the influence of socialization upon career choice. This issue can be addressed in relation to the women in the present study to see how socialization has influenced them or how they have countered it.

3.2.3 Life stage/life role theory

While trait and factor theory encouraged the development of scales and tests to determine best person-environment fit, other researchers began to explore how and why people make career choices. Alongside Piaget and Erikson's developmental schema, life stage career theories, based on normative development, were conceptualised. Ginzberg, Ginsburg, Axelrad and Herma in the 1950s had developed a developmental schema. They had theorised that, from pre-teenhood to young adulthood, individuals pass through fantasy, tentative and realistic stages. They posited the idea that choice of vocation is influenced by a

reality factor (exploration, crystallization and specification), the influence of the educational process, an emotional factor and individual values. Baird and Kram (1983) and Thompson, Baker and Smallwood (1986) looked at career stages, developing ideas around the following model of four stages: establishment; advancement; maintenance and withdrawal.

Super, however, was the main lifespan theorist for several decades from the 1950s onwards and he produced more inventories for evaluation of an individual's career development than any other, for example the *Work Values Inventory* which measures the importance of values and the *Salience Inventory* which was designed to explore life-career goals. Super described his theory as an archway and later as a rainbow in which six life roles exist in a schematic life space (Super, 1957, 1969, 1980.) The six roles are child, student, leisurite, citizen, worker and homemaker. Life stages in his framework were growth, exploration, establishment, maintenance and disengagement that one could return through at various times but that loosely associated with the childhood, adolescence, young adulthood and so on to preparedness for retirement. Super's ongoing work on lifespan career development theory (Super, 1980) provides another framework to add to trait and factor approaches for careers work. Self-concept was a key concept in Super's theories and remains a key concept in career theory today. However, tools like the rainbow have omitted the specific issues of minority groups such as women, the disabled, various ethnicities and the poor, etc, and were based on research on white middle class men. It should be noted that Super look at a variety of career patterns rather than stages for women and described them as: stable homemaking, conventional, stable working, double track, interrupted, unstable, and multiple trial (Nicholson, 1996; Super, 1957.)

Super's career theory has been used in numerous studies. In one study of Australian female dietitians, Super's career stage model was shown as useful for conceptualising women's career development and showing that different issues and values surface at different times during one's career (Smart, 1998.) Women's remuneration and job-task satisfaction were lowest in the exploration stage. In the establishment stage they were

significantly more satisfied with their remuneration and were far less willing to relocate in order to gain promotion. Women in the maintenance stage were more committed and actively involved in their career development process than women in the other stages. Newhouse-Maiden (2002) undertook doctoral research into the career development of women working in engineering using both the career archway and career rainbow. She identified gender as the main socio-cultural factor influencing their career decision-making.

Life stage/life role theory is relevant to the present study because it offers a conceptualization of career development over a lifetime with normative stages and roles. It will be useful to assess the women's stories, which are told chronologically and therefore are narrated through life stages, in order to see what normative and non-normative factors come into play when a woman experiences psychiatric illness.

3.2.4 Career stage theory

Notions of normative development can be found in human development theory and, since general knowledge about life stages such as pre-teenhood, teenagerhood, young adulthood and middle age, etc, is so pervasive and locked in (with rituals such as 21st birthdays and 'traditions' such as the midlife crisis), it clearly underpins an individual's perception of themselves as belonging in society as an individual and citizen or as feeling alienated. Their sense of belonging or alienation depends upon how closely they fit the normative descriptions of developmental stages that they experience via the media, their family/community and workplaces.

Baird and Kram (1983) and Thompson, Baker and Smallwood (1986) looked at career stages rather than life stages thereby unhooking career from an age-related schema. They theorised the useful cognitive schema of establishment, advancement, maintenance and withdrawal to show the lifecycle of any given career. Hopson and Adams (1976) looked at the stages evident in career transitions. They see an individual cognitively going through

stages of immobilisation, minimization, self-doubt, letting go, testing out, searching for meaning and internalising as they go through a transition in their career, such as redundancy, retirement or the end of elite sports and dance careers. Sugarman (2004) identified seven slightly different stages which accompany transition: immobilization, mood reactions, minimization, letting go/breaking with the past, testing or exploring the new situation, searching for meaning in the experience and integration (feeling comfortable with the change). Sugarman's seven transitional stages have been used in studies with the disabled, such as those who have lost their sight (Ponchillia & Ponchillia, 1996). There has also been a small amount of work done theorising adult crises, such re-entering the workforce after time away (Morgan & Foster, 1999) and the experience of sexual harassment and its effect upon career development for an individual, from gender harassment through to outright sexual assault (Fitzgerald & Shullman 1985; Paludi, DeFour, Attah & Betts, 1999.) Career transition phases are seen to operate in these situations (Sharf, 2002.)

Nancy Schlossberg developed a comprehensive Transition Theory in 1981 (Schlossberg, 1981) and on through the 1980s, and it was updated in 1995 (Schlossberg, 1995) to fit with general adult development theory. By 1989, Schlossberg had identified four 'S's which mediate an individual's coping ability when it comes to transitions - situation, self, support and strategies (Schlossberg, 1995.) The central aspects of the theory are that career transitions are differentiated as anticipated and unanticipated, and 'non-events' are identified as anticipated transitions that, however, have not occurred for some reason.²⁹ Transitions can be 'on-time' or 'off-time' according to how timely they are in an individual's life. Also, transitions can only be perceived as occurring if the individual identifies them as having happened. In Schlossberg's theory, the impact of the transition is evaluated according to how much the individual's life is altered by it (Goodman, Schlossberg & Anderson, 2006;

²⁹ Non-events are differentiated as 'personal' (ie, due to the individual's hopes and dreams), 'resultant' (ie, caused by an event occurring in the individual's life), 'ripple' (ie, occurring due to someone else's 'non-event'), or 'delayed' (ie, still anticipating an event.)

Schlossberg, Waters & Goodman, 1995.) It is clear that the psychology and constructivism of the individual is important to this theory.

One of the most recent studies on women's career transitions was undertaken, in 2007, by Cabrera. 497 women graduates of an international business school were surveyed to look at their career transitions. Almost half of the women had stopped working at some point in their careers (one third of whom had stopped due to child rearing responsibilities.) Of those who stopped working, 70 percent returned to work. It was found that time taken off work made career development more difficult upon return to work. Almost two thirds of the women surveyed felt that their career focus had changed over time. Mid-career women were interested in finding work-life balance (Cabrera, 2007; Sullivan & Mainiero, 2008.)

Career stage theory is relevant to the present study because its main focus on career transition will help with examining the transitional nature of the women in the present study's careers as they negotiate the world of work while experiencing psychiatric illness. A career stage focus is also uncoupled from life stages and this may shed some light on the shape of the women's careers in the present study, since they have what have been traditionally seen as non-normative experience of life stages due to psychiatric illness, despite sociology and career theory's recent assertion that all events in a life are, in fact, part of one's career.

3.2.5 Psychology of career choice

What is interesting about any stage-based theory – whether career stage or life stage – is that the stages are seen as mutually exclusive and progression linear, with participants cycling through the stages. This does not necessarily allow for psychological complexities in the individual and the messiness of human decision-making and identity formation. There has also been theorizing around careers which does not look at stages – whether life- or career-based – but rather conceptualizes careers as having different qualities. Steffre in the 1960s looked at identity formation through work, and, rather than looking at stages,

addressed the issue in terms of psychological relationships of attachment and integration by the individual towards work. Steffre (UNESCO, 2002) sees relationships between the private self and one's occupational self-concept ranging from low congruence to full congruence.

Different career types have been identified by a variety of theorists over time (Arthur, Hall & Lawrence, 1989) as suiting different psychological temperaments. The linear career type explains the conventional notion of upward progression through an organisation from, for example, intern to colleague to supervisor to manager to executive. This type of career is steadily disappearing in a volatile economic environment and as hierarchies in organisations begin to flatten. A career might plateau at a certain point on the linear progression and not move on for a variety of reasons. It might necessitate a career change. Identification of this career type is attributed to Dalton *et al* (Arthur, Hall & Lawrence, 1989.) A steady state career type explains the kind of career where development is only undertaken in order to keep one's skills up-to-date thereby securing ongoing employment. Organisational advancement is less important than enjoyment of one's work. The spiral career type explains a situation where a career in a particular field generalises outwards from a definite role remaining in the original field of work (or conversely moves towards a definite role after a variety of vocational experiences in the field of work.)

A portfolio career type explains a person having variety of different roles/occupations for which a pattern may only be apparent in hindsight. This career type is often attributed to consultancy work. Work is project-based and often over-lapping. Identification of this career type is attributed to Charles Handy (Arthur, Hall & Lawrence, 1989.)

A patchwork career type³⁰ explains a career based, economically, on the need to adapt to economic variables and survive financially, or, psychologically, on the changing interests of the individual overtime. No discernable patterning is identifiable in hindsight.

³⁰ Mills (2000) has identified that women have patchwork careers more often than men.

Identification of this career type is attributed to Robin Linnecar (Arthur, Hall & Lawrence, 1989.)

Lastly, a kaleidoscope career type is a relational model of career that is related specifically to women and shows how different patternings to women's careers emerge based on which relationships their careers are being evaluated through. A theory of this career type was developed by Mainiero and Sullivan. Mainiero and Sullivan's Kaleidoscope Career Model (Mainiero & Sullivan 2005 and 2006; Sullivan & Mainiero, 2008) is seen as useful in understanding Cabrera's findings (Cabrera, 2007) and also has been used to conceptualise women's experience of stress over a lifespan (Sullivan & Mainiero, 2006.) Challenge in early career, balance in mid-career and authenticity in later career are identified as career anchors for women as they transition through life stages in the Kaleidoscope Career Model.

Schein's notion (1990, 1996) of 'career anchors' has provided an understanding of individual career development as it is associated with psychological needs and the make-up of different human characteristics. Schein feels that an individual's self-concept, core values, motivations, and physical and psychological needs serve to provide a springboard from which career decisions are made. He sees career anchors as underpinning career thoughts and behaviour and lists them as: technical/functional competence (enjoying being good at one's work); general managerial competence (pursuit of success, prestige and the ability to focus on working with people and using executive problem-solving skills); autonomy/independence (a need to work to one's own agenda and by one's own rubric, usually alone); security/stability (a need for stable income and continuity of vocational experience without major psychological upheavals and economic risks); entrepreneurial creativity (a need to be inventive, own one's ideas and products and achieve wealth as a sign of success, while employing others to increase one's productivity and economic base); service (prosocial dedication to a cause with a view to helping others and less importance on power, prestige and wealth); pure challenge (the need for constant stimulation high level

problem-solving and risk taking for psychological stimulation as much as economic gain); and lifestyle (the need for integration of one's entire way of living, where the lines between work and other aspects of life become integrated). Travel or work in leisure areas for both monetary gain and personal fulfilment may also be part of this final career anchor. Blustein, Walbridge, Freidlander, and Palladino (1991) have found that, for women, attachment produces commitment to career decisions and less tendency to alter a career decision than for men. Danziger and Valency's Israeli study (2006) of both men and women has found that there are significant differences between the genders in terms of career anchors, in all but the technical/functional and security anchors. They found that for both genders where there was congruence between a person's career or job and a person's career anchor then job satisfaction was much more likely.

Theory based on the psychological of career choice is relevant to the present study because it provides a sophisticated understanding of the psychological underpinnings that influence career development in an individual. This may help to explain some of the career development choices of the women in the present study, who experience psychiatric illness and may have particular psychological needs due to this that may affect their sense of self-efficacy and job satisfaction.

3.2.6 Social Cognitive Career Theory

Theorists have also looked at career development from a sociological position. Career theories have been developed that attempt to address issues of culture, gender, genetic endowment, social context and unexpected life events. Such theories include Lent, Brown and Hackett's Social Cognitive Career Theory. Lent, Brown and Hackett (1994) developed Social Cognitive Career Theory out of Bandura's social cognitive theory in an attempt to address genetic endowment, gender, culture, social context and unexpected life events that may interact with, or supersede, the effects of career-related choices. Social Cognitive

Career Theory conceptualizes cultural learning experiences as making a positive or negative impact on an individual's agency. According to Social Cognitive Career Theory, vocational choice is influenced by the individual's beliefs as they are shaped by: a) accomplishments, b) vicarious learning, c) social persuasion and d) physiological states. Success reinforces self-efficacy and confidence in future success. Developmental factors influence this theory. An individual narrows their focus to successful experiences and career choice and vocational goals become fine tuned. One's context either reinforces or subverts one's view of one's success and this influences how much one's sense of self-efficacy develops. The sense of a dynamic process operating in terms of vocational identity and sense of self-efficacy makes this theory appealing in relation to the present research. It examines the place of self-reflexivity and contextual factors in career development and for this reason suits a study such as this that has social constructionism as its conceptual basis (its theoretical underpinning) and narrative analysis as one of its theoretical tools.

In 1996, Hackett and Byars reviewed literature on African American women's career development to identify the way in which social cognitive mechanisms operate for them. More recently Chronister and McWhirter (2003) have applied the constructs of Social Cognitive Career Theory to the sociocultural context of battered women's experiences in order to understand better the way the women's social learning due to their experience impacts upon their decision-making. In 2007, Cunningham, Doherty and Gregg used Social Cognitive Career Theory to understand the under-representation of women in coaching. They found that women associated fewer positive outcomes with being a head coach if they had less head coaching self-efficacy, and were less interested or motivated towards becoming a head coach due to their social learning. These and other studies show that Social Cognitive Career Theory has proven a useful construct to conceptualise women's life and career issues.

Social Cognitive Career Theory is relevant to the present study because it conceptualizes the meaning-making attempts individuals undertake and how they are

indivisibly linked to socio-cultural factors. This theory looks at self-reflexivity and context-specific learning and how socio-cultural factors (in the case of the present study such factors being experience of mental distress) can affect normative life stage career development and complicate simple trait and factor attempts at career decision-making.

3.2.7 Social Learning Theory

Krumboltz's Social Learning Theory is similar to Social Cognitive Career Theory. It is concerned with genetic endowment, learning experiences, task-approach skills and environmental factors (Sharf, 2002.) Krumboltz's theory, like Social Cognitive Career Theory, is based on Bandura's (1977) social learning theory agreeing that human behaviour is learned by observing others, modelling social behaviour and then modifying that action through ongoing reciprocal influence from cognitive, behavioural and environmental factors. Learning as a concept is central to this theory. Krumboltz (1994) identifies instrumental learning experience (genetic endowment, socio-political conditions, and political and cultural influences) and associative learning experience (classical conditioning and observation of others). He sees these learning experiences as providing the foundation for meaning-making and development of beliefs, decisions-making around actions to be taken, and identity formation. To Krumboltz's mind (1994 & 1996) these learning experiences activate both negative and positive self-observation generalisations in the individual (ie, constantly updated beliefs about one's abilities relative to others) and also task approach skills (ie, the ability to judge probabilities and possibilities in terms of career choice due to being able to relate self-observation generalisations to the outside world.) Career counselling work on self-observation can be used to elicit interests and values from an individual as well as their personal 'theory' on the world of work. Career counselling work on task approach skills can help in that they can be challenged and modified through the career counselling process if they have become counterproductive to an individual. Alternatively, they can be reinforced if

they underpin workable evaluations of career direction for an individual (Sharf, 2002.) Gruca, Ethington and Pascarella (1988) have looked at intergenerational college graduation patterns to see how they have influenced atypical career choice in women that does not fit gendered perceptions. Social learning theory was used to conceptualise why there was an influence between college graduation patterns intergenerationally and such career choices in women. Henderson, in 2003, used social learning theory to investigate how women manage their learning and overcome career obstacles. The study found that lifelong learning should be promoted since lifelong learning influences the meaning-making, goals and attitude of women towards their careers.

Social learning theory is relevant to the present study because it can provide an analysis of the kinds of learning from experience that the women in the present study have undertaken and how this has shaped their career development and life choices. It fits with a social constructionist framework and a symbolic interactionist analysis in that it shows how social learning changes the individual over time and affects their identity formation which in turn affects their career choices.

3.2.8 Planned Happenstance Theory

Planned happenstance theory (Mitchell, Levin, & Krumboltz, 1999) is an expansion of social learning theory (Krumboltz, 1994, 1996.) It focuses on the nature of unpredictability, suggesting that individuals are able to make better use of chance events than they realise, as long as they remain playful, goal-oriented, curious, persistent, flexible, optimistic and actively available in the community to come across chance events that can turn out positively career-wise (Mitchell, Levin, & Krumboltz, 1999.) An active approach to opportunities rather than a passive fatalistic approach is required to maximise career potential (Mitchell, Levin, & Krumboltz, 1999.) Career clients are to be encouraged to explore situations in order to generate opportunities for chance events to assist them in providing career opportunities or skills development. This approach is seen as an effective in

countering 'career indecision' since it values open-mindedness to recognise, and flexibility to incorporate, chance events into one's career development. The perceived impact of chance events on counselling and psychology career choices has been explored by Williams, Soeprapto, Like, Touradji, Hess, and Hill (1998) in a small scale study of women. The study found that chance events most often affected career choices when they changed participants' career paths entirely.

Planned happenstance theory is relevant to the present study because, while the participants in the present study have not been counseled to use this approach in their career development, some of them may show planned happenstance type behaviour and, if so, it would be interesting to note what kind of circumstances might lead an individual in their situation to do so.

3.2.9 Constructivist theory

Since the 1980s, constructivist research has come to the fore in the area of career development. Much as the cognitive work of Hopson and Adams (1976) and Sugarman (2004) addressed the cognitive processes that one goes through to make a career transition, Savickas (1993) was interested in fitting the world (or the individual's meaning-making about their world) into the individual's life rather than the individual into the world of work in the old trait and factor way. Savickas wanted to make sense of the constructivist cognitions of people in the world of work. He wanted to explain career decision-making in terms of understanding a client's constructs and how they influence career decision-making. Patton and McMahon's Systems Theory Framework provides a theoretical underpinning for much constructivist work in career development, including brief solution-focussed approaches (Miller, 2004b, 2006b.) Systems Theory Framework recognises a recursiveness (within the individual and also between the individual and the context they are in), the importance of change over time, and elements of chance (McMahon, 2005.) The human individual is a

system in its own right; intrapersonal influences are its subsystems. Moreover, in the Systems Theory Framework, the individual is a subsystem itself in a much larger contextual system. This is a complex theory and has been very useful in providing a comprehensive view of the world in which the individual symbolically interacts and makes career choices based on their own meaning-making. It also takes note of the milieu in which individuals find themselves and the ways in which individuals are governed by the interactions – oppositional or acquiescent – they have with hegemonic structures and influences socio-culturally, economically and politically.

Cochran, as well as Young, Valach and Collin (2002), and also Jepsen (1984), viewing career development constructively, went on to develop their own narrative approaches to career counselling where life is viewed as a story or a novel (Sharf, 2002.) Cochran's has become the predominant approach (Cochran, 1997.) Cochran views career as a story where the narrator is the agent describing the setting and the action, and uses various instruments – abilities, friends, family – to achieve goals. When clients waver in their story-telling – when there is a pause – it can be used to help them make decisions through utilising various exercises such as clarifying their aspirations, values and needs and also reassessing their resources (Cochran, 1997.) Future narratives can also be elicited from the client in a career counselling setting (Sharf, 2002.)

Constructivist and particularly narrative career theory has been popular in researching career issues. Ekonen (n.d.) has looked at women managers' career development in high technology companies using a narrative approach fitting women into 'success story' or 'victim' narratives about their achievements and putting their stories into four types: balance-seeking, hierarchical, ideological and horizontal. Also, studying women managers, but this time researching why they leave the workforce, Marshall (1995) has used a narrative approach to show that women operate in a world where different areas of their lives are discordant with one another and they have to speak "multiple languages" (Marshall

1995, p. 326) and that women are dissatisfied with “employment and organizational cultures in their current dominant forms” (Marshall 1995, p. 326.)

Constructivist career theory is relevant to the present study because it focuses on the individual's meaning-making, through interactions and self-reflexivity, as central to their identity formation and self-efficacy. It lends itself well to a study of how women negotiate mental illness and the social meaning ascribed to it. Since the present study looks at women's narratives, narrative career theory can help to examine the women's career decision-making, planning and understanding and make sense of their story-making about their lives.

3.2.10 Lifecareer and Integrative Life Planning approaches

The final element of career theory outlined here is the process approach to career decision-making that looks at the ‘human spirit’ of an individual. Hansen (1996) sees it as often “ignored in career and life planning.” Certainly researchers such as Miller-Tiedemann, from the late ‘80s to the new millennium, with her Lifecareer Theory (1988) and Lips-Wiersma in Aotearoa/New Zealand (2002a, 2002b) have looked at integrating spirituality into career counselling. Hansen's Integrative Life Planning (ILP) has a spiritual component with life values as well as work values being an important component of ILP thinking, and a shift away from materialism being signalled as important in career planning, that brings with it notions of ‘downshifting’ (Saltzman, 1991) and the pursuit of happiness via a “life of sufficiency rather than excess” (Durning, 1995, p.68.) Miller-Tiedeman's Lifecareer Theory (1988) and Sunny Hanson's Integrative Life Planning Theory (ILP) (1996, 2001) focus on the whole life of an individual and how life decision-making impacts career decision-making.

Miller-Tiedeman (Sharf, 2002) developed Lifecareer Theory as a client-focussed theory in which the narrative of the client is listened to and they are shown how their life is in fact a career. Personal rather than common reality is privileged. Critical judgement of one's

self is discouraged and acceptance of one's life career is encouraged so that meaning-making can be developed that helps guide future career decisions in a harmonious way. Clients are encouraged to learn about themselves and their world, to assess their experience and to make plans which are open to modification. Enthusiasm about change is fostered and the client is helped to feel relaxed and not under time-pressure to make decisions (Miller-Tiedeman, 1988.) The aim is for the client to experience a sense of 'flow' in their lives (Sharf, 2002.) An understanding of Flow Theory (Csikszentmihalyi, 1996) is useful in exploring the kind of outcome which Lifecareer Theory is attempting to achieve for clients.

In 1975 psychologist Mihaly Csikszentmihalyi interviewed people who described their optimum experiences using the metaphor of being carried along on a current – being totally immersed in what they were doing and being successful in the endeavour. From this the term 'flow' was developed. Many different disciplines now use the term. Csikszentmihalyi described eight parts to the flow experience that, however, did not all have to be present for flow to be occurring; but a substantial number did need to be present. These were: clarity in terms of goals, a high degree of concentration on a limited field of attention, loss of self-consciousness, obvious success and failure within the timeframe of the experience, intrinsic value in the activities so that rewards are evident in the act itself, a good balance between how challenging the endeavour is and the abilities of the person, an altered sense of time (often a substantial amount of time passing unnoticed) the opportunity to work at a deep level and totally focus to the point of full absorption, and control over the activity resting with the person undertaking it (Csikszentmihalyi, 1996; Turner, 1982.) Lack of flow could be said to be expressed as lack of meaning and 'fit' in the world, and a lack of control over one's actions and one's environment in the world of work (Turner, 1982.)

Like Miller-Tiedeman's Lifecareer Theory, Sunny Hansen's Integrative Life Planning theory, is a process type career theory and a spiritual type of career development theory. Sunny Hansen developed integrative life planning as an holistic approach to career decision-making. Hansen (1996, 2001) conceptualises six life tasks in the career development of an

individual that indicate that broader life planning is necessary rather than a narrower career planning approach. These life tasks comprise understanding the impact of family issues upon career/life decision-making, being cognisant of societal and economic situations and how they impact upon the individual's career/life decision-making as well as learning to adapt to changing conditions and to predict and prepare for future changes. Also, it is important, according to Hansen, to celebrate diversity and articulate how cultural issues impact career/life decision-making. Integration of the domains of personal life and career (including an understanding of gender issues) in order to facilitate more sophisticated career/life decision-making is also important, as is connecting life purpose and spirituality to career/life decision-making.

Hansen also talks about a sense of vocation as a spiritual aspect of career planning, as well as the act of "finding work that needs doing" (Hansen, 1996, p. 254), integrating work and family, and valuing pluralism/diversity as altruistic, pro-social aspects of career planning. In a sense, these last aspects are more secular than spiritual but they do speak of a less economically driven, individualistic and culturally imperialist view of the western notion of work and career (Durning, 1993.) Hansen feels that issues of identity (for example, gender, sexuality, ethnicity, educational development, the meaning of work, age and ability) are important considerations when addressing life and career decision-making. They need to be unpacked and evaluated by the client and career development professional. There has been no work specifically on women that has been derived from Integrative Life Planning and Lifecareer theory at this point in time. There has, however, been work looking at the importance of spiritual beliefs for African-American women in leadership positions (Robinson, 1996) and also studies on the role of vocation in women's lives (Wolf, 1990.) It should be noted that the taha wairua aspect of Durie's Whare Tapa Wha model, covered in Chapter Two, is a complex contribution from Aotearoa/New Zealand to the idea of both spiritual belief and, more broadly, cultural identity as fundamental components of a functional lifecareer.

Lifecareer Theory and Integrative Life Planning are both relevant to the present study because a holistic approach looks at life as career and finds both career and life inextricably linked rather than compartmentalizing career as one aspect of life, something that the women may experience as they negotiate psychiatric illness.

3.2.11 A note on Aotearoa/New Zealand

It is worth getting a picture of career research in Aotearoa/New Zealand at this point. Since Aotearoa/New Zealand is a western industrialised nation operating currently in a neo-liberal climate – the dominant socio-economic and political ideology in the developed world (Lauder & Hughes, 1999) – it can be theorised that some of the career ideas coming from the US can be applied to Aotearoa/New Zealand (Furbish, 2007.) Watson (2004) makes the point that US career ideas have not so much been imposed on non-American westernised nations so much as adopted due to a lack of action on the part of other countries to looking at contextual differences. The relevance of this section to the present study is mainly that it shows that complex career research and theorizing has in fact been undertaken in this country since the economic upheaval of the 1980s, and also that international career theory has been consciously rather than lazily adopted in Aotearoa/New Zealand as a theoretical underpinning to career practice.

The Department of Labour took over employment counselling from the Department of Education due to economic restructuring to a more neo-liberal model in the mid-1980s (De Grip, Hoevenberg & Willems, 1997.) Inkson and Elkin (1997, p. 420) note that the deregulation that occurred in this era in Aotearoa/New Zealand led to the destruction of “apparently impregnable career hierarchies ... [C]areer monopolies based on secure public-service hierarchies or protected professional associations [were] also disappearing ... more and more jobs [were] temporary ... All the pressure [seemed] to be in the direction of less, rather than more, stability in the structures which traditionally support rational, hierarchical,

long-term careers.” Inkson and Elkin make the important point that the psychology of individuals attempting to negotiate the world of work at this time may well have not been in step with the reality of the situation in which they found themselves:

Employees construct unrealistic timetables for the achievement of career goals. Pyramids turn out to have plateau [sic], to the disillusion of those imbued in the hierarchical ideal. The ‘public’ definition of career success in terms of status, power, money, etc, may be seductively destructive ... career paths are far from clear, in terms of both their objective existence and their subjective reality to individuals. (1997, p. 421)

Since that time, career scholarship in Aotearoa/New Zealand has examined the issues which arose from this fundamental socio-economic change in the world of careers. The following table highlights some key examples of this:

Table 3 - Examples of career scholarship conducted in Aotearoa/New Zealand and published in Aotearoa/New Zealand and overseas

Decade	Authors	Research focus
1980s	Robins, 1981 Roburgh & Stacey, 1987	The efficacy of employment preparation and job seeking skills into schools; Mid-life career changers.
1990s	Ellis & Wheeler, 1991 Cawsey & Inkson, 1992a Hood, 1998	The gender imbalance in favour of men in top management positions; The nature of career moves by managers including downsizing; The ‘whole class’ nature and low status of career development in schools; the blurring lines between formal and vocational education.
2000s	Te Puni Kokiri - Ministry of M•ori Development, 2001; Furbish & Reid, 2003 Hipkins & Vaughan, 2002; Furbish & Ker, 2002; Furbish, 2003, 2004, 2007	Career services for M•ori and M•ori needs in career planning; The failures of career services in schools and the need for professionalization of practitioners

Vaughan, Roberts & Gardiner, 2006	The importance of career drivers for career identity formation in young people and crucial elements in school to work transitions;
Furbish, 1999; Miller, 2003, 2004a; 2004b, 2006a, 2006b	The effectiveness of wider counseling in practices in careers counseling;
Lips-Wiersma, 2002a, 2002b	Spiritual influences pro-social career purpose.

Suffice to say scholarly work on career development has been undertaken for some decades in Aotearoa/New Zealand. Studies of the state of careers practice in Aotearoa/New Zealand can furnish the interested reader with an even more comprehensive picture. These include reviews by Furbish (2002) and Inkson, Furbish and Parker (2002), the special careers editions of the *Career Planning and Adult Development Journal* (Bloch, 1994; Hu, 1997) and the *New Zealand Journal of Counselling* (Brodie, 2004), and also Prideaux and Creed's review (2002) of career research in Australia and New Zealand from 1995-2000. These reviews have noted that there is a preference for Holland's model among many researchers, a need to undertake further career decision-making research, a need for more biculturally appropriate research³¹, and a gap in terms of effective career education programmes in terms of design, implementation and evaluation.

What can be said of Aotearoa/New Zealand's career development practitioners and scholars is that they have largely continued the American idea of a developmental approach to careers, based on stages widely acknowledged in human development, and borrowing from US developmental theorists, such as Super, and also the trait and factor approaches made so popular in the US by Holland. Furbish (2007) sees this as being based on universal career issues which make US career theory applicable and adaptable to the Aotearoa/New Zealand context. Indeed, Tuck and Keeling (1992) developed an Aotearoa/New Zealand version of the jobs section of the Holland's *Self Directed Search* in the early 1990s. For this

³¹ Athanasou and Torrance (2002) have also reviewed career development in the Pacific Islands.

reason, it is appropriate that the present study uses international career development theory to understand the data collected from the women who gave their stories about their experience of mental distress/psychiatric illness and its impact on their careers in Aotearoa/New Zealand.

3.3 Career development literature on women

3.3.1 Introduction

Inkson and Elkin note that:

Women's careers are often perceived, especially by men, in terms of discrete intervals of time, bounded up by the word 'until' ... until she marries, until she has children ... until the youngest child starts work ... until the mortgage is paid off. (1997, p. 416)

As Boyle (1997) notes, women experience a different positioning in society. Their discourses are different from men's (Radte & Stam, 1994; Smart, 1992.) Career issues for women are necessarily positioned around issues that are primary for women. Some of these might match men's issues, but many do not. Many career theories assume that individuals are free to make occupational choices based on values, interests and abilities. However, choice is restricted by the socio-economic and political environment as it interacts with many facets such as age, race, ability, gender, sexuality and religious affiliation (Brooks, 1990; Brown, 2002; Walsh & Heppner, 2006.) This sociological implication has been recognized by some theorists and a body of career theory around women and careers has developed over time.

Since most of the research around work and psychiatric illness is gender unaware and since the present study is based around women's experience, with several of the women identifying as lesbian or bisexual, it is worth looking at career development literature in relation to women and then specifically in relation to lesbian, which is what this section undertakes to do.

3.3.2 An overview of literature on women and career development

There have been many career development approaches developed specifically in relation to women. Super (1957) was the first career theorist to identify that there were career development issues affecting women in particular. He focused on the domestic role of women in the home and posited seven different types of career patterning for women including the interrupted career pattern. What he did was to identify specifically that women have multiple roles with regard to both career and family. In 1966, Holland, when he began to develop his universal approach to career typology (Holland, 1985, 1992, 1996), did acknowledge, albeit uncritically, gender differences in occupational distribution between the genders. Psathas (1968) discussed sociological factors such as marital status and family finances in relation to status attainment for women but his idea that women took roles such as teaching, administration and nursing in order to marry into an upwardly mobile situation was deeply uncritical. In a similarly uncritical vein, a year later, Zytowski (1969) looked particularly at women's domestic roles, seeing women as 'naturally' home-makers (based around the roles of 'married woman' and 'mother'), and noting that this home-makers role was not compatible with complex and far-ranging career aspirations. However, in an admirably sophisticated analysis, as early as 1974, Hansen (1974) perceived that there were distinct limitations to current theories on women's abilities to develop their careers. The socialization of girls and role conflict in terms of domestic and vocational desires had certainly started to be considered, but Hansen also looked at the way sexism affected women's career development and also saw changing social trends as impacting on women's career development. Career advisors are seen in the role of change-agent and advocate. This is a politicized model that requires critical literacy on the part of both the career professional and the client. Hansen predicted that the issue would be looked at in more sophisticated ways in future decades, and was correct in this assumption. She went on to develop an 'integrative life planning model' that centred around an holistic approach

integrating the multiple elements of human life and acknowledging the role that gender, culture, and community affect both women and men (Hansen, 2001.)

In 1980, Super (1980) introduced a life-space into his 'career rainbow' theory that acknowledged the multiple roles women have, including home-maker and worker. Fitzgerald and Crites (1979) had felt that putting the role of home-maker in the realm of career exacerbates the already undervalued status of women in the non home-making workforce; they did not see it as an occupational signifier of constructive use in a career approach that seeks to acknowledge inequalities. It is not a neutral signifier to them as it was to Super at this time. A year later, Gottfredson (1981) put forward a developmental life stage theory that was worked on through to the mid-1990s (Gottfredson, 1996.) Gottfredson's theory took account of gender roles and status attainment in decision-making. Gottfredson termed two processes in this theory 'circumscription' and 'compromise'. The first referred to gender influencing occupational preference and the latter referred to the modification of career choice due to limiting factors. Gottfredson looked particularly at the early sex-role socialization of girls in terms of roles that were deemed appropriate for their gender, or not, and looked at social variables, such as social class and gender, that constrict career decision-making by engendering a weak sense of self-efficacy in relation to occupations. Her thesis was that sex-role socialization was the last variable to be given up at times of compromise.

Also in 1981, Hackett and Betz (1981) developed a model of self-efficacy that levered off Bandura's theory on self efficacy in the 1970s (Bandura, 1977.) Gender socialization was given as the reason for women's different cognitive behaviour from men's in relation to the traditional vocational roles for women and men. Put simply, women expect to have less self-efficacy vocationally and this affects their choices and persistence. In 1982, Raynor (1982) saw a reflexivity between career and self-concept. Essentially, how we think about ourselves as gendered beings influences our careers and conversely what career status attainment we

have influences our sense of self. In 1983, Osipow (1983) asserted that gender differences give rise to the need for specific career development frameworks for each gender.³²

This was a strong and sophisticated call for more depth in career theory around gender. A year later, Astin (1984) asserted that women and men have the same work motivation but early socialisation and societal structures create differences. The problem with Astin's work was that, while it looked at the structural constraints around vocational opportunity, it made work the central role and did not look at conflictual issues around occupation and family life. Farmer in 1984 (Farmer, 1997) looked at the psychological architecture that produces 'home-career conflict' and, in 1985, (Farmer, 1997) developed a model of career motivation that looked at background sociological factors, including gender and parental influence, as impacting on career attainment motivation. She went on (1997) to develop her model in a post-structuralist vein, looking at sex-role socialization's impact on women's self concept and stressing the possibility for agency in the individual despite such socialization. Farmer, in the mid-1980s, felt that women needed to develop a persistence in science learning due to the impact of academic role socialization that gave girls and women what Betz and Fitzgerald (1987) and Betz and Hackett (1983) would term 'maths anxiety'. Fassinger (1990) notes that there have been a number of studies on maths self-efficacy in women and girls that found females have less confidence than males in this area and that this affects their career choices.

Gilbert in 1985 (Gilbert, Hallet & Eldridge, 1994) saw a tri-partate model existing in terms of the career development roles of couples, ranging from 'traditional' (male worker, female homemaker) through to 'participant' (a sharing of roles, but where women still do most of the homemaking) and on to 'role sharing' (where the roles are equal). There was no foresight at this time, in Gilbert's model, to another type of role for couples where the male was a 'stay-at-home dad' and the woman a careerist. However, there had been insight from

³² As Kate Millet put it 14 years earlier in her PhD thesis that went on to become a best-selling book – *Sexual Politics*: "Because of our social circumstances, male and female are really two cultures and their life experiences are utterly different" (Millet, 1969, p. 31.)

others into the fact that women were socialized to connect with others and choose occupations accordingly, whereas men were socialized to differentiate from others and be individualistic (Chodorow, 1978; Gilligan, 1977, 1982; Lyons, 1983.) Forrest and Mikolaitis (1986) felt that 'connected' people, predominantly women, chose service occupations where they could be in contact with other people as a prime part of their job, and this indicated why males, who were not socialized traditionally to be 'connected,' did not enter these roles. Hayes (Affleck, Morgan & Hayes, 1989) also posited the idea that male impulses to 'differentiate' from other males and get ahead could in fact be satisfied for some males through entry into predominantly female-occupied service occupations, because there was more opportunity for advancement to leadership positions (for example, there are few primary school teachers who are male but they are disproportionately represented as school principals.)

By 1986, there were feminist assertions that men's work was artificial but that women's work was essential in terms of the future progress of humanity (Rose, 1986.) Also, Hayes (Affleck, Morgan & Hayes, 1989) was writing that men who chose traditionally female occupations would have both their masculinity and their sexuality examined negatively by others. Lease (2003) used a longitudinal study to examine this idea, which had subsequently been put forward by Chusmir too (1990), and found that prestige was less of a factor in career decision-making at the end of a college degree for males (due to the liberal formal and non-formal learning acquired in tertiary study) than it was prior to entry to college when socio-economic status and other socio-cultural factors were more directly an influence on whether a male wanted a traditional male career route or not. In 1987, Betz and Fitzgerald (1987) reviewing the literature at that time identified four specific sets of variables that influence women's career choices. These were termed 'individual', 'background', 'educational' and 'adult lifestyle' factors. Betz and Fitzgerald developed, with Fassinger, in 1989 (Fitzgerald, Fassinger & Betz, 1995) a 'model of career choice realism' to explain the behaviour of highly vocationally able women which Fassinger refined in 1990 to include

more variables including 'feminist orientation'. A year earlier Gallos (1989) had spoken about the need for different voices to be viewed from different perspectives, specifically in relation to women. At this time the second wave feminist view was strong in theoretical work on women. With males specifically in mind in 1987, Larwood and Gutek (1987) mentioned the fact that direct career theory work on women, which was proliferating under the strength of feminism as a theoretical perspective, might broaden what was currently a narrow field of study and also improve the situation for men who did not fit the traditional male role. Queer theory would go on to do this broadening work in the new millennium.

Betz and Fitzgerald, in 1987, looked at the role of mothering as a determinant for a daughter's career development. They saw the maternal attitude to careers for women as being more important than the mother's actual career. They would go on to look at the many variables within 'family of origin' influence (such as sibling influence, family structure and family dysfunction) on girls. Sex discrimination would still be seen as a factor for women despite societal shifts towards more women being in varied roles in the workforce. By 1989, Betz (1989) talked about the vicarious way in which girls learn things – the informal learning at home, school and in the community. While in teaching the concept of a 'null curriculum' was being developed to explain all of the things *not* taught in schools (such as positive views of homosexuality), in career development theory, Betz (1989) put forward the notion of a 'null environment' as one that does not take account of women's career dreams and attainment. In 1991, Ferber and O'Farrell (1991) saw a connection between those women who are careerist having more decision-making power in the home than non-careerist women. This may be because such women have a higher self-esteem due to status and prestige as well as a more developed differentiating and individualistic self-concept than women who are more 'connected' in outlook and therefore more sacrificing when it comes to role division between the workplace and the family home. In 1992, Fitzgerald and Weitsman (1992) put forward the anti-essentialist social-constructionist notion that men and women are not fundamentally different in terms of career except for the complexity of the 'socialization

process' that has occurred for women and not for men since industrialization in the West. Kerr and Maresh (1994) and Hollinger and Fleming (1992) saw this socialization process as creating the gap between aptitude and achievement in talented women leading to the adoption of lower status jobs than were merited intellectually.

In 1993, Farmer *et al* (1993) posited the idea that some women decide not to pursue demanding careers due to role conflict with their roles as female family members. O'Brien and Fassinger at this time (1993) were looking at the role of parents in socializing girls out of certain careers, echoing Betz and Fitzgerald's 1987 work on mothering.³³ From 1994 to 1996, Lent along with colleagues including Brown and Hackett (the latter, as previously mentioned, had worked on socio-cognitive models of self-efficacy with Betz in the early 1980s) produced a social cognitive theory of vocational self-efficacy based on variables including learning factors (Lent, Brown & Hackett, 1996.) This added to the growing body of literature that saw contextual determinants operating in terms of career choices. In the same year, Eccles (1994) blamed 'society' (ie, family members, educators, communities and the State) for failing to give women the message that they should maximize their full potential vocationally. Betz (1995) reiterated earlier claims that girls were socialized out of occupational roles and thereby vocationally restricted.

In 1997, Poole and Langan-Fox (1997) looked at what was lacking in theories on women's careers and identified that variables such as 'disconnection', 'transitions', 'constraint', 'conflict and compromise' and 'lives-in-context' were not strongly represented enough. Their model (1997) sought to rectify this. Farmer, in 1997, asserted that the male bread-winner role was an uncomplicated one for males because the occupational socialization of males is clear-cut and does not require the sophistication of combining roles that the occupational socialization for women requires. The male role was seen as an active provider role whereas the female role was seen as sacrificial and multi-layered. Farmer cites

³³ Betz and Fitzgerald would go on (2001) to look further at parental influences on career development for women, emphasizing the need for positive parental support as a contributing factor in a woman's career success.

Betz's work (Betz, 1993) on the 'family role' of each gender limiting women's vocational investment while increasing the male provider orientation. Farmer also cites Kinnier, Katz and Berry's 1991 study in which 'career-family conflict' in married heterosexual couples who had children tended to revolve around the dominant theme of family having to come first (Kinnier, Katz & Berry, 1991.) Farmer also notes that if, for women, the benefits of having a family, and thereby multiple roles, outweighs the stressors inherent in the multiple role, then Siber's 1994 theory of 'role accumulation' shows that family life and married life for women can be fulfilling (Siber, 1994, cited in Farmer, 1997.) For Farmer, however, such fulfilling situations are far and few between, as the dominant orientation for women in this situation is, to Farmer's mind, to career and role conflict. Betz and Fitzgerald (1987), Betz (1993) and Silberstein (1992) had seen multiple roles and socialised expectations of primary home-making and child-rearing as being, for most women, vocationally stressful and a source of ongoing role conflict. One way of women attempting to ameliorate this situation for themselves, was, in Farmer's thinking (1997) for them to unravel their value-system into what is crucial and what has been socialized into them. Farmer criticises both Super (1990) and Holland (1985) for not looking at women's roles at this level of sophistication, ie, in terms of socialization impacting negatively on the importance women put on the vocational role they take in society.

An alternative feminist reading of role conflict in women (focusing more on what might be termed an 'earth mother' type role for women) had been put forward by Marshall in 1989 (Marshall, 1995). Marshall theorised that socialized roles for women provide women with 'transferable competencies' that are positive tools in their vocational life. In the same year, Gallos (1996)) reinforced Marshall's view that women's contribution to work is vastly underestimated due to the fact that a male definition of employment is what is most valued in society. Gallos felt that the female 'ethic of caring' undermined their value in society as workers. This echoed Eccles' view (1989; Oswald & Harvey, 2003) that women's choices about work are inextricably bound up with their family-based roles. By the 1990s, Fitzgerald

and Weitzman (1992) had come to see this issue less in terms of intrinsic female work-values that are under-valued by society, as their counterparts had seen it in the 1980s, and more as women compromising vocationally not because of a lack of career interest towards traditionally male roles but in order to gain congruence between the multiple demands of their various societal roles.

Career development debates in the 1990s went on during a time in which the economic environment meant that dual careers (Ellis & Wheeler, 1991; Gupta, 1993) were largely necessary for many couples with children, making role conflict for women largely unavoidable (Farmer, 1997.) Also, women had been conscientised by feminism into expecting more from work outside the home but were still restricted by gender role stereotyping. Farmer (1997) saw it as vital at this time that women planned for multiple roles. What is clear is that, at the end of the twentieth century and on into the new millennium, women largely attempted to integrate family and work roles, with varying degrees of success, rather than choosing between them (Hallett & Gilbert, 1997.) It should also be noted that such attempts were taking place in a workplace environment where a new conceptualization of careers was required – one in which nonlinear careers were becoming the new norm (Fitzgerald & Harmon, 2001.)

Patton and McMahon by the end of the twentieth century (1999), in reviewing the work done on career theory around women, felt that it was still at a developmental stage despite over 30 years of work on the topic. They felt that issues of gender were complex, intersecting as they do with other socio-cultural and psychological influences and contextual factors in career development. There is little unified thinking at this juncture in history with regard to women and careers, except a steadily growing acknowledgement of sociological factors impacting cognitive processes and impinging on life chances in terms of sex-role stereotyping, socialization and opportunity. Many authors had acknowledged the role of discrimination and structural barriers to women's career development, such as assumptions that they would give up work upon marrying, sexual harassment in the workplace, pay

disparity, lack of advancement and expectations of being less vocationally competent than men (Betz, 1993; Betz & Fitzgerald, 1987; Cinamon & Rich, 2002; Eccles, 1994; Farmer, 1997; Limerick, Cranston & Andersen, 2006; White, Cox & Cooper, 1992.)

In the last two decades of the twentieth century, theoretical work focusing on the role of cognition (for example, vocational self-concept and self-efficacy mediated as they are by socialization and sociological variables such as ethnicity and social class) was undertaken by several scholars (Fitzgerald & Weitzman, 1992; Forrest & Mikolaitis, 1986; Gottfredson, 1981, 1996; Hackett & Betz, 1981;; Hollinger, 1991; Hollinger & Fleming, 1992; White, Cox & Cooper, 1992;.) They looked at the female orientation towards relating to other people, and the importance of easy employability, as affecting job choice (for example, the over-representation of women in teaching and nursing.)³⁴ They also looked at women's compromising behaviours, and at the status of women's work as low-paid, casual and part-time (Williams, 2005), as being part of a female cognitive strategy to gain congruence with other roles, such as family roles. Fitzgerald and Rounds (1993) felt that flexi-time, worksite childcare and more flexible parental leave could counter this problem. Findings showed that a substantial number of women did not seem to have realized their vocational dreams or the level of employment achievement for which they were intellectually suited, perhaps, according to Simpson (2000), because of the gender imbalance in organizational culture in terms of management positions that led to a culture of female invisibility at management levels and men being more comfortable hiring other men for management roles.

In the new millennium, other theoretical work was developed in terms of women and career development. Warrington & Younger (2000) looked at gender disparity in the United Kingdom and found that an alienation process occurred for girls in terms of traditionally male academic subjects and that career dreams were markedly gendered. Watson, Quatman, & Edler (2002) found that this applied less to students at single-sex girls' schools. Parental

³⁴ Holland's hexagon's categories of Realistic and Investigative were seen as largely closed off to women by Fitzgerald and Weitzman (1992) due to socialization and vocational compromise. Osipow and Fitzgerald (1996) see female-dominated jobs as being 'pink collar' (though the term 'pink' is usually ascribed to homosexual concerns, such as 'pink triangle' and 'pink dollar'.)

support for higher career aspirations in these girls seemed to be greater. Furthermore, teachers had a better rapport with, and higher expectations of, their female students than teachers did with girls at co-ed schools.

Also in the new millennium a spiritual career development theory began to strengthen, with a view that one's life was seen as being one's actual career, a notion that fits with the alternative feminist view of Marshall (1995.) As Sharf says:

You are not looking for a career, [sic] you have one. Life is our career. By trusting inner wisdom ... you can experience your career ... [it is] a spiritual approach to career decision making. (2002, p. 383-4)

There is, so far, no literature focusing on the impact of spiritual career development theories on women's career aspirations and career satisfaction, though Hansen (2001) did develop integrative life planning and looked at integrating work, community and family life through holistic life planning.

Betz (2002) also described an ecological approach to career development for women. In the early years of the millennium, this holism was central to looking at women's careers. A narrative or storied approach to career counselling also began to take shape in career development practice in general. It placed the person at the centre of their own career and life narrative with the power to unpack the ways they have been socialized and to challenge some of their thinking around their abilities and aspirations, remodeling their cognitive approach to work and life based on new knowledge about the world of work and their place in it. While not specifically women-focused, this approach had a lot to offer women (and minority groups) because of its potential to reframe identity and transform thinking, and thereby professional practice, in the vocational realm.

What can be seen from this review of the career literature on women is that there has been consistent debate and theorizing around women's issues since the late 1970s and that most of the major career theories have been examined in light of their usefulness for explaining what appears to be a complex situation for women with regard to the world of work and career. Researchers have added more sophistication to the important work of

Super and have espoused cognitive, constructivist and sociological views of what is happening for women in society in terms of their career development. The proliferation of different theories about career development has helped to provide an underpinning to some detailed theorizing about the obstacles and concerns faced by women.

This section is relevant to the present study because it provides detailed examination of career concerns for women and shows how major theories over the decades have been espoused and re-examined in the light of women's concerns. It will help to provide a sophisticated analysis of what is happening for the women in the present study as they negotiate the world of work while experiencing psychiatric illness. What should be said about this section is that, much as mainstream career theory is gender-unaware, women's career theory could be accused of being sexuality-unaware. For this reason – and because several of the women in the present study are lesbian or bisexual – literature on lesbian, gay, bisexual and transgendered (termed LGBT in some quarters) career development is covered in the next section.

3.3.3 Lesbians and career development

It is important, for the purposes of this study's scope, to have focussed on surveying the specifically career-development based literature on lesbianism and work. Several of the women in this study are or have been in lesbian relationships. In 1995, research recommendations for four components of lesbian and gay career development were made after a review of all existing literature at that point in time (Pope, 1995.) From 1940 to 1993, thirty one articles had been written in total on the subject of lesbian and gay career development. Pope notes that the early literature is methodologically weak. As a research area, it is still coming out of the closet. Pope's four identified areas were – lesbian issues, gay male issues, career choice, and career counselling interventions. It was recommended that these areas guide future research into lesbian, gay, bisexual and transgendered career

development. Since then there has been a growth in empirical research with a focus mainly on external environmental factors such as discrimination and human rights (Chung 2001; Croteau, 1996; Fassinger, 1996.) Only a little of the recommended research on internal psychological factors such as career decision-making – career choice – has been undertaken (Boatwright, Gilbert, Forrest & Ketzenberger, 1996; Mobley & Slaney, 1996; Morrow, Gore & Campbell, 1996.)

Dunne (1997) sees lesbian research as being research on non-heterosexual women. This is an unhelpful notion since it sees lesbian women only through the lens of their otherness in counterpart to the dominant sexuality. It offers a deficit model for lesbian women to fit into. It leads to the type of research that looks uncritically at the home/work dual roles of lesbian couples in comparison to heterosexual women and their male partners (Gilbert, Hallett & Eldridge, 1994.) Views of domestic advantage for lesbian couples in terms of housekeeping and parenting, and the idea that there may be a reduction in stress for lesbian women co-habiting, are simplistic and do not take into account the multiplicity of relationships that exist in lesbian circles as well as the impact of homophobia – both internalised and external – on lesbian women (Haines, 1987.) How does simplistic thinking on ‘lesbian’ being the opposite of ‘heterosexual woman’ take account of the lesbian, for example, who explores self expression through more ‘butch’ masculine behaviours? (Cox, Johnson, Newitz & Sandell, 1997.) While heterosexuality largely differentiates between masculine and feminine along sex lines (cross-dressing is an example where this is not always the case) it cannot be assumed that homosexuality does also. Masculine and feminine are more fluidly expressed perhaps due to a lack of gender enforcement commensurate to that imposed on heterosexuals. Already being ‘other-ed’ allows the homosexual identity to explore a fluidity of gendered expression. For example, a woman might take on a more domestic role in one relationship whereas in another relationship, or in another phase of her life, she might be the breadwinner. A lesbian woman might begin as a lesbian feminist with separatist politics and move through to adopting a more ‘queer’

orientation later in life where she explores more traditionally masculine behaviours through dress and sexual expression. Or the converse might be true.

One difficulty when looking at lesbian, gay, bisexual and transgender literature is to locate sufficiently broad and in-depth lesbian-specific aspects. Those career-related research studies which combine lesbian, bisexual and male homosexual research participants, and provide some differentiation in the results write-up, are valuable (Chung, 1995; Croteau & Hedstrom, 1993.) Obviously lesbians are uniquely different in some respects to gay men, bisexual and heterosexual *non-feminist* women, and heterosexual or bisexual *feminist* women, but there are also commonalities. What must be noted is the middle-class dominance of the scant lesbian career-development literature that exists (Eldridge, 1987; Fassinger, 1995, 1996; Schneider & McCurdy-Myers, 1999.) This is congruent with bell hooks assertion (1987, p. 95) that: “attitudes towards work in much [women’s] writing reflect bourgeois class biases.” Such a bias slants research towards women in the professions (eg, business, medicine and education.) What can be said about lesbian career development from the literature is that, in terms of the vocational psychology of lesbians, identity issues may cause lesbians to neglect career development issues, particularly in adolescence (Boatwright, Gilbert, Forrest & Ketzenberger, 1996; Elliot, 1993; Fassinger, 1995; Morgan & Brown, 1991; Walsh & Heppner, 2006.)

While there is little career theory specifically about lesbian career development, there are papers concerned with how to address lesbian and gay issues within the theories of Super (Dunkle, 1996), Holland (Mobley & Slaney, 1996) and sociocognitive theory (Morrow, Gore & Campbell, 1996.) What is written about careers is largely by lesbian, gay, bisexual and/or transgender authors about ‘coming out’ in the workplace (O’Byrne, 2003) or by non-lesbian, gay, bisexual and transgender identified authors about the gendered difference between heterosexual and homosexual career couples (Gilbert, Hallett & Eldridge, 1994.) Apart from the occasional intelligent comment on the fact that some existing theories are inapplicable to a certain degree with regard to lesbian and gay men’s career concerns (Betz,

1994; Patton & McMahon, 1999), plus one excellent three-page overview of lesbian and gay issues in career development (Patton & McMahon, 1999), the amount of lesbian career development literature by non-LGBT authors is largely offensively brief and relatively meaningless (Fitzgerald & Betz, 1994.) In the occasional chapter of non-lesbian, gay, bisexual and transgender authored career development texts, as has been mentioned above, the lesbian couple is compared on the issue of housework and equal sharing of home responsibilities quite favourably with the heterosexual career couple whose experiences are seen to be redolent still with the legacy of patriarchy (Gilbert, Hallett & Eldridge, 1994.) One is reminded of the corporate women's riposte about wishing she had a wife, in some management books on women in the 1980s and 1990s (Cooper & Davidson, 1983; Ellis & Wheeler, 1991.) These facile comments aside, there is room for study on the actualities of lesbian career coupledness rather than extrapolations being made that the lack of a male in the relationship leads to household labour equality, or that a woman needs a 'wife' to be a successful careerist. Lesbian couples are seen by Gilbert, Hallett & Eldridge (1994) as having:

... neither the power dynamics implicit in heterosexual relationships, nor the norms and roles ... [they are] socialised to value egalitarian relations with other women engender[ing] role-sharing relationships in lesbian couples. (1994, p. 136)

As Foucault (1980) and many others would attest, power relationships exist in all human relationships and the notion of a relationship 'power vacuum' certainly would be a naïve assumption with regard to lesbians. There are many lesbian norms and roles in the subculture. For example, variations on the butch and femme roles of the 1950s in the West are still in existence in some relationships. Gilbert, Hallett & Eldridge fail to cover the variables present in the ways that women construct their identities as lesbians and as lesbian couples, families and co-habitants. It would seem that Gilbert, Hallett & Eldridge are confusing lesbians with feminists or viewing lesbianism as a counter to patriarchal stereotypes in heterosexual relationships. In doing so, they diminish the diversity of lesbianism and lesbian relationships. Lesbian couples are not 'other' to heterosexual couples; they are not an undifferentiated dual-wife/non-husband dyad.

Any 'reading' of the lesbian career couple needs to be more sophisticated than a concrete stereotype of the non-differentiated couple, and there are few signs of existing career development literature doing that. No acknowledgement is given of the fluidity between and within genders and sexualities as opposed to a single duality of male and female hegemonic workplace and home-life social constructs that are patriarchally and heterocentrically assumptive. It could be argued that a more empowering position in the literature for the lesbian career couple would be to have no reference made to it at all rather than stereotypical references based on conjecture and underpinned by no empirical research.

The concept 'identity-management' is used by some lesbian, gay, bisexual and transgender researchers (Quinlivan, 1993) to look at the place of lesbians in the workplace, with a focus on the dangers of 'coming out'. Coming out is the focus of much lesbian, gay, bisexual and transgender work-context research, especially in teaching occupations (O'Byrne, 2003.) Chung (2001) uses the concept of identity management in his research into homophobic discrimination – where one is 'out' in varying degrees to some colleagues, but not others at work. Teaching and social work studies provide most of the non-career development type literature on lesbian issues in employment. Interestingly, while non-lesbian, gay, bisexual and transgender authored career development literature sees the lesbian career couple as an effective housecleaning dyad, the social work literature sees the lack of social recognition in lesbian relationships as causing domestic problems for working lesbian partners in terms of social role validation and failure to define and communicate expectations around household issues (Peterson & Stewart, 1994) as do Eldridge's studies that have been done specifically on lesbian dual career couples (Eldridge, 1987; Eldridge & Gilbert, 1990.) There is a heavy focus in this literature on homophobia and its effects on social status or access to social services based on employment status – an employment status that can be negatively affected by limitations in employment/career choice due to lesbian identity and societal homophobia (Wilton, 2000.)

Attention to career development issues may occur later in life for lesbians who come out during adolescence than for their heterosexual counterparts (Morgan & Brown, 1991.) For those who come out later in life, they may be challenged to integrate their new social identity into their self-concept and work adjustment practices³⁵ in the career they already occupy (Fassinger, 1995.) This may lead to the need for a career transition to a career providing more satisfaction and a stronger sense of career self-efficacy (Fassinger, 1995.) Lesbians are seen as taking longer to achieve career-related goals and as often taking circuitous routes to achieve these goals (Boatwright, Gilbert, Forrest & Ketzenberger, 1996; Dunkle, 1996.)

Lesbians also carry the burden of double minority status based on gender and sexual orientation, and often further minority status through social class, health and disability issues and race/ethnicity (Morgan & Brown, 1991.) Positive aspects of identity for lesbians in terms of career development should be noted. They are identified as liberal gender role behaviour, the delimited impact of traditional female gender role socialization, flexibility in career planning and the ability to choose non-traditional occupations (Fassinger, 1995; Walsh & Heppner, 2006.)

A need for descriptive and explanatory career development studies, especially those which focus on personal (interior) factors such as career interests, values and skills,³⁶ rather than the usual focus on environmental (exterior) factors, was acknowledged as an important new area for future research towards the end of the last century (Chung, 1995) since personal factors heavily influence career decision-making for lesbian, gay, bisexual and transgender people as much as environmental factors. However, they have been largely overlooked due to the urgent significance for lesbian, gay, bisexual and transgender people of factors such as stigma and discrimination associated with lesbian, gay, bisexual and

³⁵ 'Workplace adjustment' is the process workers use to achieve correspondence with their workplace. The term 'satisfaction' is used to indicate that the work fulfils the worker's needs and 'satisfactoriness' is a term used to indicate that the employing organization is satisfied with the worker's performance in terms of meeting the designated tasks of their work role.

³⁶ Sharf (2002, p. 282) makes the point that: "[Values] represent judgments [sic] and evaluations that individuals have about themselves and their world. These values help individuals cope with their world ... [interests] are a connection between the individual's perceptions and social situations."

transgender status (Chung, 1995; Levine & Leonard, 1984.) In terms of personal factors, one core value influencing career choice could be the degree to which one is able to express one's sexuality safely in the world of work (Day & Schoenrade, 1997; Driscoll, Kelley & Fassinger, 1996; Ellis & Riggle, 1996), something that is a 'given' for heterosexual males and many heterosexual females today in the Western workforce.

By the new millennium a call was being made for lesbians to look at choices around 'out'-ness' or 'closet'-edness, and opportunities to find work that can be undertaken in an explicitly 'out' way (Chung, 2001.) Vocational choice strategies are shown to deal with this encompassing as they do self-employment, job tracking (working in lesbian, gay, bisexual and transgender environments with a lot of lesbian, gay, bisexual and transgender staff, solely lesbian, gay, bisexual and transgender staff or catering for lesbian, gay, bisexual and transgender communities) and risk taking (Chung 2001; Levine & Leonard, 1984.) They are underpinned and can be articulated by examining values, skills, interests, opportunities and other variables (Fassinger, 1995.) A strong self-concept has been identified as being linked to career choice optimisation in the past and lesbian, gay, bisexual and transgender employees have used work adjustment practices to make their career environment as positive towards them as possible (Fassinger, 1995.) When they are 'closeted' at work, identity management strategies come to the fore as a type of workplace adjustment practice. Being explicitly 'out' is itself not always the aim and depends on the workplace culture. Identity management strategies are largely pitched at the level of success (acceptance, equality, viability for promotion at work) expected in the circumstances. This sense of one's capacity to succeed is referred to in this context as career self-efficacy (Chung, 2001.)

In closing, it is to be stressed here that little research has been done on personal factors involved in career decision-making for lesbian, gay, bisexual and transgender individuals. This would be necessary to assess whether there are special work values related to minority sexual orientation (Chung, 1995.) What can be said is that the double burden of multiple minority status must be acknowledged for lesbian women in the present

study due to their experience of minority sexuality and of psychiatric illness. This section has helped to provide some sophistication to the non-differentiated literature on dual-career couples and has also shown that issues of discrimination and disclosure are always present for lesbian, gay, bisexual and transgendered people in society and in the world of work in particular. How this impacts with discrimination and disclosure issues for the women in the present study with regard to psychiatric illness will be interesting to note.

3.3.4 A note on Aotearoa/New Zealand

The working 'individual' in the 1960s in Aotearoa/New Zealand was mostly likely to be male. By 1966 around 40 percent of women were in paid employment. This grew to roughly 50 percent in 1976 and around 66 percent in 1987. Men's participation in the workforce was 93 percent in 1966 and 83 percent in 1976 (New Zealand Department of Statistics, 1990.) Māori participation rates have always been lower than Pākehā's except in the 15-19 age group. Education has been cited as a main factor for the rise in women's participation in the workforce over time, as well as couples having children later and having fewer children. What must be made clear here is that the rise in women's participation in the workforce was largely via the development of part-time work as a trend and has always been concentrated in a few key industries such as community and social services, nursing, teaching and customer service/administration. In 1990, women made up 90 percent of all medical, dental and veterinary workers, but only 33 percent of vets, doctors and dentists were women. Unpaid work both in the home and community has throughout the twentieth century been the preserve mainly of women. Importantly, since 1971, 56 percent of the rise in numbers of women in the New Zealand workforce has been due to part-time work (New Zealand Department of Statistics, 1990.) A marked rise in the 1980s was in the proportion of women aged 40-54 in the workforce. Despite this, women's participation in the Aotearoa/New Zealand workforce was less than men's from the 1960s through to the 1990s.

The literature on women and careers is scant in Aotearoa/New Zealand but there have been a few studies, including the a study on women's accounts of their experiences of redundancy in Aotearoa/New Zealand (Hancock, 1981; Hill, 1979) and a study looking at women's experience of conforming to male stereotypes in order to work in the New Zealand parliament (Baysting, Campbell & Dagg, 1993.) Also, in 1979 and early 1980, a study of 100 New Zealand women with the surname Smith was undertaken about various aspects of their lives including work (Barrington & Gray, 1981; Haines, 1987.) While the section on work is small in the book that came out of the study – *The Smith Women* – it did find that most of the Smith women had begun work by the end of their teens, their first jobs being stereotypically 'women's work' in offices, schools, hospitals, factories and shops. Many found their first jobs unsatisfactory and cycled through a series of jobs in the first few years of work. Fathers had a lot of input into helping the Smith women into their first jobs. The authors delineate between skilled and unskilled jobs and professions. A quarter of the women were in professions by the time of the study and almost half were in skilled jobs. University experience led to less traditionally female careers, for example computer programming and research. Barrington and Gray feel that less qualified women had less job satisfaction because of less sense of direction and fewer skills with which to bargain. Only a few women saw their jobs as careers and they all had qualifications, a vast amount of experience, of both. Most women had expected to give up work once they had children and three quarters of the women surveyed did have children. However, many did return to work. Childless women had to work around their husband's career needs. The authors concluded that the age of 18-23 is crucial for women in terms of their future direction – career or otherwise.

What is relevant to the present study here is the sense that, for P•keh•, women's issues in Aotearoa/New Zealand can be seen to echo those of other Western women when it comes to unpaid and underpaid work and the casual or part-time nature of their employment. Issues of childrearing and family influence upon career are also clearly evident in Aotearoa/New Zealand as they are for women elsewhere. This gives the present study a

framework for understanding the socio-economic and socio-cultural climate in which women experience their lives and careers in Aotearoa/New Zealand.

3.4 Psychiatric illness and career development

3.4.1 Introduction

As Gupta notes (1993, p. 15): “the stigma of a mental disorder has tremendous potential to ruin not only personal and family life, but one’s career.” It is appropriate, therefore, that a lot of mental health research has looked at employment issues for people with psychiatric illness, particularly rehabilitation literature. Psychiatric vocational rehabilitation is concerned itself with the 3-5 per cent of the population who suffer chronic, debilitating episodic or ongoing mental distress (the demographic of this study.)

Job loss is one of the top ten traumatic life experiences according to Spera, Buhrfeind and Pennebaker (1994.) Social supports and mental health are seen to decrease over time for the unemployed as their unemployment progresses (Warr, 1987; Warr, Jackson & Bank, 1988.) Women in the general population who had a central ‘career orientation’ to their work rather than a marginal ‘job orientation’ seemed to suffer worse mental distress from unemployment (Warr, Jackson & Bank, 1988.) To understand the impact of job loss on a Western mind, one must examine the meaning of work in the West.

Work is a central facet of life in New Zealand as in other Western economies. Like schooling (Ramirez & Boli, 1994), work is a compulsory component of modern life that most people cannot opt out of. Work can create links with other members of society outside the family of origin and create an identity outside of the one derived from family and marital status. It is also bound up with socio-economic status and for this reason is crucial for most Westerners to deal with well in order for them to survive and thrive in modern society. Work in the West can be equated with success and prestige as well as economic power and this

can enhance or diminish the individual's sense positive self-concept. As Neff (2006, p. 6-7) comments: "to be able to work in a work-oriented society is to be 'like' others ... unemployment can only exacerbate feelings of worthlessness and low self-esteem." There are choices available for different types of occupations, circumscribed as these choices are by education, geographical location, social class, gender, ability and age. Affiliation and integration with one's society can stem from a positive career experience whereas alienation from society can occur if negative experiences occur.

Western notions of work are strongly linked to Western ideas of linear human progress in the modern world.³⁷ There is much argument as to whether notions of human societal progress existed in the Classical era of Greece and Rome or even in the Enlightenment era (Nisbet, 1980.) Some critics see it as beginning with Christianity and some as beginning with modernity (Nisbet, 1980.) Whatever its origins, the idea of progress most certainly exists in the modern Western world as a hegemonic discourse and is closely allied with utopian discourses (Nisbett, 1980.) Progress as a Western notion is currently becoming globalised. It sees technological development and higher consumption as equating to human progress when, in fact, from a Malthusian perspective, they could threaten our very existence on the planet (Bronk, 1998; Gomes, 2002.) We believe that we are on a course of progression as a species and a society and such belief legitimises our corporatist behaviour (Myerson, 2001) as Western nations, despite evidence of it producing environmental destruction, rampant consumer consumption and the 'necessary evil' of unemployment as a balance to inflation (Gomes, 2002.)

Politics aside, both Western liberalism and socialism agree on existence of progress in human history and as a facet of human civilisation (Seidman, 1994.) However, the idea of human progress may only be a construct through which human beings are able to make sense of the world and agree on the direction society takes. It may be little more than a

³⁷ Other discourses, of decay away from a golden human era, exist both in non-Western belief systems (eg, Vedantic thought) and in ideologies such as postmodern ecological and political thought (Bronk, 1998.) Hindus have a long tradition of thought in which civilisation is seen to be decaying rather than progressing over the last 5,000 years.

comforting myth masking a dominant ideology (Rose, 1965.) A Foucauldian (1980) view of human civilisation denies that progress is made generation upon generation, and instead sees power and society as constantly being reshaped for the betterment of some and the disadvantage of others (Seidman, 1994.)

Critics are divided on how long the notion of progress has been dominant in Western thought, but the individualised economic notion of progress most certainly underpins modernity and belief systems such as the 'Protestant work ethic' (Weber, 2002.) This ethic, growing out of Lutheran thought, is based on a belief in hard work for future gain – originally a gain after death in heaven – and, more recently, also on believing fundamentally in “positive change over a single lifetime” (Bronk, 1998, p. 25.) It is internalised by many Westerners so that it appears to them to be a core truth, a reality (de Botton, 2009). Progress is seen to ultimately lead to personal freedom,³⁸ and, linked with moral progress, to an eventual societal utopia (Bronk, 1998) that, from both a Marxian and a neo-liberal perspective, exists in the eventual homogenisation of society due to the reaching of a natural end-point in socio-cultural evolution (Fukuyama, 1992) and the end of “creative tension between different traditions” (Bronk, 1998, p. 238.)

It is a 'given' in the modernist hegemonic discourse of progress that improvement in personal circumstances should be the outcome of personal endeavour (de Botton, 2009.) After the neo-liberal projects of the last 30-40 years, the experiences of many people around the world have not supported this supposition (Beder, 2000.) To the contrary, they have suffered when they have found that their careers have plateau-ed, are non-linear or have even led to redundancy and dependency on social welfare. In addition, they have seen others in society acquire more economic power to consume and more social status and prestige. Due to the internalised 'Protestant work ethic' (Weber, 2002) such an individual could feel culpable for failing to live up personally to a cultural imperative – that of betterment

³⁸ Adam Smith's treatise – *Wealth of Nations* (on economic progress being fundamentally individualised) links individual economic progress with individual freedom in Western consciousness (Nisbett, 1980; Lauder & Hughes, 1999.)

and progress (de Botton, 2009.) From this it can be seen that job loss for any member of society can be a traumatic event. Osipow and Fitzgerald (1993) in the 1990s noted that job loss could impact on the mental health of the general population and that services to help the general unemployed with their mental health were inadequate.

The general population aside, job loss/unemployment often is an experience of those going through a period of psychiatric illness. Psychiatric illness can also mean that one is precluded from certain forms of work because of one's illness, either due to its symptomology or the stipulations of the job being that one does not have a psychiatric illness (for example, the job of a civil aviation pilot). Disability from psychiatric illness is seen to exist when symptoms have continued for more than a six month period (Athanasou, 1999.) It can, however, be seen as a social phenomenon rather than a merely medical phenomenon, due to the impact of discrimination, stigma and lack of social accommodations (Oliver, 1997; Wight Felske, 1994.) Disability, according to Shahnasarian (2001) can lead to job loss and diminished access to occupational opportunities, a need for workplace accommodations, employer bias and a diminished worklife expectancy leading to fewer career development opportunities, compromised career growth, a lower than average income and a longer time than average looking for work when unemployed (Pilgrim & Rogers, 1999.) All of these elements have severe implications for the career health of an individual with a disability. Job loss itself, whether caused by mental illness or not, has its own mental health implications and should be viewed as part of the process of debilitation that can lead to further disability.

This section is relevant to the present study because it shows that individuals with psychiatric illness are seen to be affected by the discourses predominant in the cultural milieu in which they exist and by the economic and political issues in of their society. This can create self-blaming discourses and create another layer of discrimination for the individual with a psychiatric illness. It will be interesting to see if this is borne out in the narratives of the participants in the present study.

3.4.2 Rehabilitation literature

The next section looks at vocational rehabilitation after job loss due to psychiatric illness, and at competitive employment and career development issues. Also recent research on employment issues for people with mental illness that has been specifically undertaken in Aotearoa/New Zealand will be covered. Vocational rehabilitation is primarily – and often uncritically (Oliver, 1989a) – concerned with restoring the individual to a worklife in which they can maintain vocational functioning (Neff, 2006). From a brief look at the rehabilitation literature it would seem that there are problems with current rehabilitative practices for people with experience of living with psychiatric illness, for example lack of focus on job preference (Becker, Drake, Bond & Xie, 1998), inadequate focus on environmental barriers (Lal & Mercier, 2002) and a lack of intersectorial approaches (Lal & Mercier, 2002.) Rehabilitation has been defined as the process by which an individual is “restored to a state of optimal effectiveness and given an opportunity to enjoy a meaningful life” (Hirschberg, Lewis & Thomas, 1964, p. 6.) Psychiatric illness is the second largest category of disability catered for by vocational rehabilitation programmes but these programmes have shown limited efficacy (Bond & Mayer, 1999; Garske & Stewart, 1999.) It has been noted that research studies have had conflicting findings in terms of whether “clinical and demographic variables are consistent predictors of future vocational performance of psychiatric patients” (Tsang, Ng & Leung, 2000.) Research undertaken in the 1960s and 1970s has been perceived as largely methodologically unsound due to unreliable information gathering methodologies in terms of employment outcomes and diagnosis of psychiatric disorder (Tsang, 2001.) Such research was also undertaken at a time of high hospitalization (often lifelong) and the use of lobotomies and older type medications.

In the mid-1980s, Neff (2006) noted that, since vocational rehabilitation programmes were small scale and selective in terms of admission, it was hard to assess these services in terms of their success, but that they appeared to have little “noticeable impact on the post-hospital careers of the more severely mentally disordered” (1985, p. 246.) It could also be

said, since vocational rehabilitation focuses on the severely psychiatrically ill (Garske, 1999), that as long as it continues to do so it cannot have any real impact on the employment of more moderately psychiatrically ill people struggling with vocational issues. And yet these people also suffer from hardship in simple everyday social tasks such as entering shops, talking to friends, remaining motivated and being able to concentrate adequately (Garske, 1999) – social and procedural issues that translate into problems in the workplace as much as in society. Vocational rehabilitation services focus on skills-based learning and trait and factor type issues (Garkse, 1999) rather than constructivist models of career intervention that focus on the self-concept and meaning making of the individual in relationship to work and careers (Raeye, 1999.)

While rehabilitation is limited in terms of its approach and its target population, it does provide us with useful findings that can inform career development research into psychiatric illness. Anthony and Jansen's (1984) review of the literature on employability in the very psychiatrically ill and Stauffer's (1986) review of literature from 1960 to 1985 – despite being undertaken in the early to mid 1980s – are both held as comprehensive and useful, particularly Anthony and Jansen's (Tsang, 2001.) Anthony and Jansen's (1984) major findings from their review were that: psychiatric illness symptoms or diagnosis, plus test results for intelligence, aptitude and personality do not predict future work outcomes; there is barely any correlation between symptomology and functionality; and ability to function well in one's home environment does not translate into a different kind of environment. They also found that an individual with psychiatric illness's prior employment history is a critical factor in predicting their future employment success, as are their social skills and co-operative approaches towards others. Also clinical predictors of future employment success are most accurate when made in workshop or supported employment settings or when based on assessing the strength of the self-concept of the individual in terms of how their sense of self is based on the role of 'worker' in society.

Stauffer (1986) found that evaluation tools and test scores, demographics (such as marital status, social class, and age etc), training undertaken by the psychiatrically ill person, staff involvement with the person outside the hospital setting and the skills gained by a person in rehabilitation settings were all helpful in predicting future employment success and job retention.

Tsang, Ng, & Leung's (2000) review of the literature over a fifteen year period from the mid 1980s to the year 2000 substantiated most of the previous findings of Anthony and Jansen (1984) and Stauffer (1986) as well as providing the new findings. They found that the functionality of the person with psychiatric illness prior to illness onset, the person's work history and their level of social skills consistently contribute to career success after illness on-set. Cognitive and family factors were also found to be of importance for work success for people with experience of living with psychiatric illness. They found that co-morbid substance abuse's impact on psychiatrically ill people's future employment success had contradictory results in studies. The strongest indicator of success was previous employment success (premorbid functioning) and, most interestingly, diagnosis and symptomology had a correlation with future employment success in the studies covered by Tsang, Ng, & Leung's literature review that countered Anthony and Jansen's findings. One would expect from this that someone with a psychotic disorder, a thought disorder or a bipolar mood disorder would have more problems with employment success than someone with depression or anxiety or that someone with a wide and persistent range of florid symptoms would have more problems with employment success than someone with intermittent or single episode symptomology.

Researchers often work from the 'given' that work has a therapeutic impact and underpins economic status and identity (Chan, Reid, Kaskkel, Roldan, Rahimi & Pmofu, 1997; Dawis, 1987; Mowbray, Bybee, Harris & McCrohan 1995; Osipow, 1968.) This 'given' reflects the acceptance of compulsory employment as 'natural' and 'normal' in many of the world's societies (Ahrens, Frey & Senn Burke, 1999), whereas from a social constructionist

perspective this can be seen simply as a structural construct in society that serves to bind communities together (Oliver, 1989a.). People with experience of psychiatric illness in the Western world live in a society in which employment is the norm, unless certain criteria are met, such as being a child, being a tertiary student, being a home-maker, and being someone with a high needs disability. The State puts in place both supportive and punitive measures to encourage employment and communities have discourses, such as the 'dole bludger' discourse, that are effective in encouraging compliance or create a kind of underclass that is seen as threatening to the community due to its opting out of the normative state of compliance to society's mores. Compulsory employment is as strongly normalized as compulsory schooling, and in vocational rehabilitation it is widely accepted that it is rehabilitatively useful for people with even severe and prolonged psychiatric illness to be in work (Garske, 1999; VandenBoom & Lustig, 1997.) However, It is well researched that people with psychiatric illness often live outside of the norm of the employed workforce (Ahrens, Frey & Senn Burke, 1999; Garske & Stewart, 1999) and that, for those people with ongoing psychiatric problems, roughly 15 percent are in competitive employment (Garske, 1999; Garske & Stewart, 1999), the rest constituting a "burden ... to society ... increased by loss of tax revenue and the cost of care" (Ahrens, Frey & Senn Burke, 1999, p. 17.) Marshak, Bostick and Turton (1990) view the vocational rehabilitation success rate of people with psychiatric illness as roughly half that of people physical disability. Anthony, Cohen and Danley (1988) view those with psychiatric illness as 'immature' in terms of vocational concerns due to their restricted experiences and narrower range of roles vocationally. This is a rather blanket statement, but it does make sense that the career development of those with psychiatric illness will be different from the norm (Caproso & Kiselica, 2004) just as it is for other minorities such as lesbian women. The issue of discrimination by others in society – one of the environmental barriers facing people with psychiatric illness in their pursuit of employment – is not to be underestimated (Bond & McDonel, 1991; Caporoso & Kiselica, 2004.)

Massel, Liberman, Mintz, Jacobs, Rush, Giannini and Zarate (1990) see 'impairments' in vocational functioning, such as problems with selecting, applying for and retaining employment as a core feature of psychiatric disorders. Others have found that predictors of job tenure – which is often brief and terminated by the person with a psychiatric illness themselves (Becker, Drake, Bond & Xie, 1998; Cook, 1992; MacDonald-Wilson, Revell, Nguyen & Peterson, 1991) – are previous work tenure (pre-morbid vocational functioning), job satisfaction from an early point in a vocational role, lower than usual autonomy in the job and higher ability to innovate (Xie, Dain, Becker & Drake, 1997). In terms of job satisfaction, McCue and Katz (1983) see people with severe psychiatric illnesses as having more problems with work adjustment (Dawis, 1987) than people with other disabilities. Maintaining a work-role has been shown to be harder than acquiring a job in the first place for many people with psychiatric illness, despite vocational support beyond the job placement phase (Becker, Drake, Bond & Xie, 1998.)

Bond (1992) notes that vocational rehabilitation services specifically for the psychiatrically ill have only become important in the world of vocational rehabilitation since the mid-80s. This would coincide with psychiatric service deinstitutionalization in Western societies. The personhood of the individual with psychiatric illness has become significantly identified with their community of origin (Garske, 1999) and thus with the world of work. According to current thinking, their personhood was diminished in the past, stunted, and even deliberately destroyed, through incarceration and human rights infringements in the 'total institution' of the psychiatric asylum (Mitchell, 1978).

A focus on encouraging normalization through vocational rehabilitation and social rehabilitation became more important than reduced symptom management and shorter stays in hospital (Drake, 1998) for a while in the late 80s and early to mid 1990s in countries like the United Kingdom, United States, Canada, Australia and Aotearoa/New Zealand. This occurred alongside deinstitutionalisation practices that evolved into community-based rehabilitation programmes, supported job placement, and consumer-oriented in-the-

community mental health treatment and management services (Garske, 1999.) What becomes clear when looking at psychiatric rehabilitation literature is that it is focussed largely on supported employment, and has some proven outcomes in this area, and is less focussed on competitive employment, for which it is not conclusively shown to be useful (Bond, Drake, Becker & Mueser, 1999.) That is to say, the psychiatric vocational rehabilitation model is largely a placement model (and it is sometimes only brief tenure of, on average, 70 days as in Xie, Dain, Becker and Drake's 1997 study) rather than a career development model. Cook (1999) feels that vocational rehabilitation can address issues around competitive employment but that there are failures in collaboration between vocational rehabilitation services and psychiatric services. There is evidence of isolated instances of partnership between vocational and psychiatric services in the 1990s. While having some positive attributes, these alliances nevertheless had low employment outcomes for the psychiatrically ill. They were collaborations based more on generating transition from one service to the next rather than holistic ongoing and comprehensive support spread amongst several agencies (Lal & Mercier, 2002.)

As Lal and Mercier (2002, p. 390) say there is a need for collaboration between psychiatric vocational rehabilitative services and other areas of society so that both "internal and external barriers to employment" can be resolved. The Individual Placement and Support Model (IPS) adds a vocational specialist to the multidisciplinary team (Becker & Drake, 1994; Lysaker & France, 1999.) Further to this there may even be a case made for general career service practitioners (suitably trained in psychiatric issues) to work with vocational rehabilitation staff, psychiatric workers and other sectors (large workplaces, income support services, etc) in order to address genuinely competitive employment issues (with the aim of high placement levels) (Bond & Meyer, 1999; Caporoso & Kiselica, 2004; Garske, 1999.) A wider population of the psychiatrically ill might be able to be catered for in this way, ie, particularly those who were in competitive employment prior to illness onset.

This section is relevant to the present study because it shows that discrete illness diagnosis and a focus on symptomology are less important than self-efficacy in assisting an individual back into work after job loss due to psychiatric illness. Self-efficacy can be seen as a psychological factor operating outside the psychiatric factors of illness and symptoms. Therefore the issue of self-efficacy will be important to consider when looking at the women's narratives. It will be necessary to guard against assumptions of lower work self-efficacy in those women who have more complex symptomology, and higher self-efficacy in those women with milder symptomology. Job loss itself is commonly an aspect of disability whatever the psychiatric diagnosis. In this way disability can be seen as a social process rather than just a medical process. It is a major transitional event for many people experiencing mental illness and the narratives of the women in the present study will be examined in light of this. Vocational rehabilitation is shown in this section to be primarily a placement model but career development conclusions can be drawn from it. The main assumption that can be made is that placement models are short-sighted and focused on normalization of vocational behaviour rather than integration of what sociologists call the career of being a mental patient (Goffman, 1961) and the rest of their life, especially the world of work. This means that a more complex career development reading should be made of the women's narratives in the present study. In other words, it will be necessary to assess the ways in which the women have dealt psychologically with job loss and been subjectively successful or unsuccessful in their vocational life post-illness onset, rather than merely recounting details of their job roles and vocational status after psychiatric illness.

3.4.3 Career development and competitive employment

What is useful for a career development study, such as this, is to look at the smaller body of rehabilitation literature that does deal more with career development issues and competitive employment. Shahnasarian (2001) puts forward an argument for shifting vocational

rehabilitation towards career rehabilitation, which encompasses more than placement and supports around placement. This is congruent with Tse and Yeats (2002) findings in their Aotearoa/New Zealand study of employment issues for people with bipolar disorder. Pumpian (1997) has also noted that ongoing career support beyond job placement is essential for people with disabilities in general. Incidentally, Burkhead and Wilson (1995) also advocate the role of the family as a resource to be used overtly in rehabilitation programmes for people with disabilities in general. Shahnasarian (2001) calls for a lifespan approach similar to Super's³⁹ which focuses on personal fulfilment in careers, not just "vocational evaluation, functional assessment, work hardening and reconditioning, work-capacity evaluation, job-site analysis, job accommodations, job-seeking skills, employer development, employment skills training, job placement, and follow-up services" (2001, p. 275.) The problem, perhaps, is that it takes considerable resources already to fulfil these placement focussed tasks with an individual. However, a career development approach might be a useful adjunct and counterbalance other more placement-oriented services by being less about traits and factors and more about disabling self-concept, ie, the psychological landscape in which a person with psychiatric illness finds him- or herself (Lysaker & France, 1999; Raeye, 1999.) An individual with a psychiatric illness often operates in a psychosocial landscape in which "problems such as poor self-image and low self-esteem can develop into tendencies to discount abilities, squelch risk taking, and spawn a self-fulfilling prophecy that reinforces underachievement" (Shahnasarian, 2001, p. 277.) Low self-concept can become a disabling factor for such people.

Neff notes that the constructivist idea of self-concept has a long tradition in psychiatric and psychological literature but that there is "little consensus regarding its components" (2006, p. 108.) There is also little use of it as a conceptual tool in rehabilitation literature. Super's theory sees 'self-concept' as something that develops dynamically over time. It is a picture of oneself that one uses to make choices in life – people are keen to

³⁹ Super (1990) is cited in Raeye (1999) as being the only career theorist incorporating disability into lifespan-oriented career theory.

make choices that feel like they most optimally fit with this picture of themselves (Neff, 2006.) For those who espouse a symbolic interactionist perspective, such an analysis can assist in forming a workable notion of what self-concept is and how it is socially constructed. Neff feels that the idea of there being a “strong linkage between self-concept and occupational choice” is too simplistic (2006, p. 108.) Perhaps this is only the case when ‘self-concept’ is narrowly and non-dynamically conceived. If self-concept is less static and computational (Neff, 2006) and more symbolically interactive, then all of the aspects of self which confuse as well as clarify what determines vocational choice and opportunity in the workplace can be taken into consideration. This view of self-concept shows that constantly reshaped and contested meanings, whether they are valid ontologically or not but which are held to be important at any given moment of decision-making, influence an individual’s interpretations and experiences (Neimeyer & Neimeyer, 1993.)

The Weberian notion of ‘life chances’ is perhaps useful here. ‘Life chances’, according to Max Weber (Hadden, 1997), are those social and economic advantages and disadvantages that people experience due to being part of particular groups in a culture, for example, due to ethnicity, sexuality, gender, social class, religious affiliation, medical status or marital status, etc. ‘Life chances’ are always altered by the groups to which we belong depending on the power, prestige, opportunity and reward that come with particular group status. It would make sense that an individual’s ‘life chances’ can positively or negatively affect an individual’s self-concept and thereby their sense of self-efficacy.

Aware of this problem for people with disability in general, Raeye (1999) advocates Patton and McMahon’s “systems-theory framework [that] considers the influences of broader context[s]” (1999, p. 22), for example, the family and the community, as a resource for people with disabilities in general. Thus, it can be seen that there has been thinking about psycho-social approaches to career development work with people with a disability, and this could be physical or psychiatric, though there will be specific additional issues for those with mental illness, for example the public’s perception of dangerousness (Garske, 1999) and the

cognitive distress of hearing threatening inner voices or having paranoid thoughts and delusions.

There is little research into the rehabilitation of professionals with experience of psychiatric illness. Botterbusch reviewed the 'Minnesota Mainstream' project in the US and found that mentoring has had some success and that career development is a complex issue for people with psychiatric disabilities and requires long-term planning as well as long-term on-going support after job placement (Botterbusch, 1999, 2000.) It is recommended that occupational goals be judged on their relative importance next to other non-occupational life goals in terms of seeking life satisfaction. Katz (1996) looked at career counselling for people with severe psychiatric disability and found that what she termed 'unrealistic' career goals can negatively affect a person's career plan. Kravetz, Dellario, Granger and Salzer (2003) mapped persons with psychiatric disabilities' work histories and found that they were commonly fragmented and contained significant periods of unemployment. They recommend a multi-sectorial approach to career development in these individuals due to the complexity of their needs.

Ronningham and Anick (2001) reviewed the progress of the Interrupted Career Group, a psychosocial programme in the United States. They found that discussion of feelings around career 'interruption' due to psychiatric illness was useful and that attending the group was useful to some participants in helping them integrate and adapt previous occupational abilities with their current level of functioning to create a productive approach to their current vocational situation. Rogers, MacDonald-Wilson, Danley, Martin and Anthony (1997) also signal the importance of frequent ongoing discussion of feelings (and emotional support from mental health professionals) for people with psychiatric illness in supported-employment situations

Krupa (2004) found that careers tended to be non-linear for people experiencing schizophrenia. Persistence and success was recorded for those individuals with: a strong

work ethic; a flexible approach to work; a growth orientation to experiences; existing pro-work orientations in the opinions of their significant others; and a lack of dependence on social welfare. Social networks providing actual vocational help were a central feature of work success for these individuals and individuals worked despite ongoing symptomology. While psychosis interfered with work routine, medication was the primary tool to combat this, paired with active problem solving strategies to manage the psychotic episode early on. Krupa found that acceptance of illness needed to be integrated into self-concept in order to create a functional occupational identity. This was, however, acknowledged to be a task that stimulated a great deal of stress in individuals. Ellison, Danley, Bromberg and Palmer-Erbs (1999) found, in a follow-up study of young adults with psychiatric disability, that career planning and skills development practices learnt in a vocational rehabilitation setting did have enduring productive outcomes.

Mueser, Becker and Wolfe (2001) found evidence to back up the 'common knowledge' assumption that job placement and support that focuses on supporting an individual towards employment congruent with their job preferences is more successful than that which does not take job preference fully into account. Torrey, Mueser, McHugo and Drake (2000) looked specifically at self-esteem as an outcome variable, using the Rosenberg Self-Esteem Scale, and found that it relates strongly to life satisfaction and stable emotional functioning and not to vocational functioning *per se*. However, a number of the same researchers the year later (Bond, Resnick, Drake, Xie, McHugo & Bebout, 2001) found, when employment is specifically looked at, that competitive employment rather than supported, minimal or no employment, led to better vocational satisfaction, better symptom management and higher self-esteem in individuals with psychiatric disabilities. Employment as opposed to unemployment has been found in a longitudinal study to relate to better self-esteem (Mueser, Becker, Torrey, Xie, Bond, Drake & Bain, 1997.) Employment programmes themselves have been shown also to increase self-esteem (Kates, Nikolaou, Baillie & Hess, 1997.)

Becker, Smith, Tanzman, Drake and Tremblay (2001) advocate integrating psychiatric and vocational services using cross-training of all staff in order to provide intensive community support for people with severe psychiatric illnesses. Torrey, Bebout, Kline, Becker, Alverson and Drake (1998) posit the idea that clinicians who integrate vocational work into their practice can help clients move beyond the patient role and into a recovering worker role. Fabian (2000) specifically looks at the usefulness of a Social Cognitive Career Theory as a framework for working with people with psychiatric illness, particularly focussing on self-efficacy and outcome expectations as a way of improving vocational functioning. Regenold, Sherman and Fenzel (1999) have found that, in the Australian context, self-efficacy is positively linked to successful vocational outcomes. Alverson, Alverson, Drake and Becker (1998) found that there are three social correlates to functionality in competitive employment for people with severe psychiatric illness. These were: optimism and a sense of the value of maintaining functionality with the help of professionals; participation in functional social groupings whether in the family, among friends, in the community or in the workplace; and the absence of long term poverty.

This section is relevant to the present study because it shows that self-concept and real interest in a particular field of work are important factors in successful return to competitive employment for people experiencing psychiatric illness as well as ongoing vocational functioning. Studies involving major career theories such as Systems Theory and Social Cognitive Career Theory back this up. Again this shows that symptomology alone need not necessarily stop a person from working in competitive employment but rather that belief systems and outcome expectations are important considerations also. This helps to shape the data analysis to ensure that it looks at beliefs, interests, and self-concept when examining the work undertaken by the women in the present study before, during and after their psychiatric illness episodes.

3.4.4 A note on Aotearoa/New Zealand

Little research on career and psychiatric illness has been done in Aotearoa/New Zealand, but what has been done is worth mentioning. In 2002, Lapsley, Nikora and Black undertook a mental health study in which they found that participants reported that very few of them continued on with their “successful career trajectories relatively unchanged” (2002, p. 91) post illness onset. Those who did were “academics, mental health professionals and people in sales” (Lapsley, Nikora & Black, 2002.) A small number of participants lived with profound regret in terms of their own career development feeling that all possibilities for them to succeed had gone. Young people were developmentally non-normative in that they adopted careers several years later than their peers. This was because their experience of psychiatric illness in their youth had caused the normative career decision-making phase to be delayed. Some participants were content in their new fields of work, necessitated by their experience of psychiatric illness, and some were even “passionate” (Lapsley, Nikora & Black, 2002) about their new field, speaking of their new work as a vocation. Many moved into careers in mental health “making a career of my history” (Lapsley, Nikora & Black, 2002.) Insight gained from their own experiences had helped other participants relate to others in their work. Many participants would not disclose their psychiatric illness on their resume or at work,⁴⁰ though one participant said she always had done so and had never experienced any problems.

Tse and Yeats study (2002) of what aids people with bipolar disorder to succeed in employment used a grounded theory approach. They found that recovery from the acute illness phase is crucial for work readiness and also that there needs to be a “goodness of fit between the individual, support, job and wider contextual components” (2002, p. 47.) One component of these four – individual attributes; support from a wide range of sources; job satisfaction and structure; and societal factors – would varyingly tend to be more significant

⁴⁰ This is congruent with Murphy’s finding (1992), with regard to learning difficulties, that people with hidden disabilities tend to not disclose them in order to gain workplace accommodations and instead use strategies to compensate.

than another and this largely depended on where the individual was in their recovery. For example, societal factors, such as income support provision and discrimination, played a more significant negative role early on in the illness. A lot of personal motivation might be required for someone who was still experiencing symptoms and learning to cope with medication issues to successfully re-enter the workforce at that stage. Subsequently, they found that there was “a wide variability with which individuals with [bipolar disorder were] able to engage in paid work” (2002, p. 55.) Samuel Tse has been instrumental in studying successful workplace participation for people with bipolar disorder (2002) with findings that self-determination and maintenance of vocational self-esteem or hope are important factors in employment success.

This literature is relevant to the present study because it reinforces, in an Aotearoa/New Zealand context, what the previous section had found, namely that optimism and a positive sense of self-efficacy are important components for occupational success. It also shows that career change of some kind after a psychiatric illness is almost always the case and that the acute phase is usually a time of vocational loss. It will be of interest to examine these notions in light of the narratives of the women in the present study.

PART B

Summary

This literature review looked at both mental distress/psychiatric illness literature and career development literature in order to provide a context in which to site the data collected in the present research. It provides a backdrop for understanding how career and psychiatric illness in Aotearoa/New Zealand have been shaped culturally and historically. It will help to unpack the issues raised by the women in their narratives in terms of psychiatric illness symptomology, professional diagnosis, treatment, disclosure, recovery, social and professional support, job loss, rehabilitation, competitive employment, gender and sexuality issues and their unique position as women in Aotearoa/New Zealand.

This literature review has made connections between psychiatric illness and vocational and social loss as well as the importance of identity issues in relation to others. Individuals with psychiatric illness are seen to be affected by the discourses predominant in the cultural milieu in which they exist and by the economic and political issues in of their society. This literature review demonstrates the entrenched but challengeable views around psychiatric illness that exist both socially and professionally, and indicates that such views do shift eventually into new forms over time. In terms of career development, it also demonstrates that career thinkers have made significant attempts to fit theory around diverse human behaviour in recent years and that career theory has taken a more holistic multifaceted person-centred approach that reflects a shift to individualism in society with all the opportunities and risks that such a paradigm poses for an individual operating within it. Vocational rehabilitation services for the mentally ill seem not to reflect this in that they continue to operate from a trait and factor job preparedness and placement approach that is unsupported by a concomitant holistic whole-person intervention. Māori can be seen to have

contemporary holistic models for health promotion and community development that might reflect a more holistic approach. There is no research literature on the efficacy of kaupapa Māori models in a vocational rehabilitation setting however.

The need that human beings have for one another – in order to define and agree upon the world they live in, to construct a paradigmatic architecture in which to understand their experiences, to be secure in their identity and confident in their choices, to be accepted and to thrive through a strong sense of self-efficacy, or indeed to struggle and fail as social beings – is made clear by this literature review. Issues of power are clear in the professionalization of the psychiatric profession and in diagnostic and treatment practices. The central role of pharmaceuticals in treatment and pharmaceutical companies in psychiatric illness classifications, as well as tensions within psychiatry over various frameworks for understanding psychiatric illness, are evident. The dominant role of the US in both diagnostics and treatment of psychiatric illness, and in the provision of core career development theories, shows Aotearoa/New Zealand existing in a globalised/Americanised psychiatric and career development context. How well this works for the participants in this study shall be shown in Sections D and E of the present research. What follows in the next section, Section C, is an account of the methodological issues and description of the methods used in the present research in order to explore the psychiatric illness and career development issues of a group of women in Aotearoa/New Zealand.

PART C – METHODOLOGY/METHOD

CHAPTER FOUR

Methodology

4.1 Introduction

This section presents the methodology adopted for the present research. It explains a rationale for the use of qualitative methods, and an overview of certain theoretical approaches to research design and data analysis. It also considers issues of researcher bias and participant wellness as factors affecting the present research. Also ethical considerations are covered such as the voluntary nature of participation, informed consent processes, the rights of the participants to withdraw from the study, anonymity and confidentiality issues and how the present research will be disseminated. The ethics approval gained prior to data collection is also explained.

4.2 Why a qualitative methodology? Initial thoughts about the research methodology rationale

I undertook a multi-case qualitative research project using grounded theory data collection methods. For data analysis purposes I used thematic analysis (Ezzy, 2002), not dissimilar to grounded theory's constant comparative research method (Strauss & Corbin, 1998; Tolich & Davidson, 1998.) This constituted one type of qualitative research. One of the key features of qualitative research is that its principles can underlie a wide range of different research approaches that can be suited to the exploration of human behaviour. As Jacob (1987, p. 1) notes: "qualitative traditions present diverse approaches to research and ... each tradition forms a coherent whole, comprising internally consistent assumptions about human nature and society, foci of study, and methodology." What all of these traditions have in common is the fact that they are guided by several qualitative principles, namely the fact that the researcher is the key research instrument and as such attempts to sit themselves in the

research, adapt to changes in the research process as they occur and also guard against biases which might damage the research; the research takes place in natural settings (often using conversational techniques) rather than testing subjects in laboratories; and that an inductive process is taken to analyse data so that the data speak to the researcher rather than the researcher imposing their own meaning onto the research (Denzin & Lincoln, 2000.) Intensive interviewing is a common technique used in qualitative research (Lofland & Lofland, 1995.) It consists of a conversation guided by the researcher that is aimed at acquiring rich data that is suitable for qualitative forms of data analysis. It provides the kind of data appropriate for conceptualising complex social phenomena and analysing human experiences, and this in turn lends itself to analysis based on social constructionism to see how meaning-making is constructed by participants in the context of the world in which they live..

In terms of the present research, there is much literature on rehabilitation around work and psychiatric illness, but not specifically on participants' sense-making to themselves in terms of work and career. Therefore, a qualitative approach with inductive, thematic analysis can provide a fresh view on a subject that has previously been dominated by a particular discipline – namely rehabilitation (Ezzy, 2002; Roberts, 2002; Stern, 1980.) A qualitative approach can take into account the socio-cultural and economic milieu in which the participant acts as a social being (Creswell, 2007.) It can address issues of gender, sexuality, ethnicity, ability and age. It can be sensitive to these sociological components of a participant's life. Since the present research hoped to gain an understanding of the motivations and actions of group of women who have experiences of psychiatric illness, a qualitative approach is best suited.

4.3 Potential theoretical constructions

Eagleton (2003, p. 2) calls theory "... a reasonably systematic reflection on our guiding assumptions." It reflects our beliefs about reality and being (ontological issues) and our

beliefs about the nature of knowledge and knowing (epistemological issues) (Denzin & Lincoln, 2005.) Added to our beliefs about knowledge construction – that is, methodological issues – theory provides a conceptual framework for any research study (Denzin & Lincoln, 2005.) In this way theory can be shown to have highly practical applications in a piece of research. As Lewin (1952, p. 169) said: “there is nothing as practical as a good theory.” As Karl Popper notes, theoretical underpinning to data analysis and discussion of findings provides an orientation for readers of the research findings and discussion to engage with the research in a critically useful way:

The benefits of ‘joining up’ [to traditions] stem not so much from inheriting world views, concepts, and methods as from having the purposes, processes, and outcomes of one’s work questioned by people who have some understanding of what one is about.” (Popper, 1970, cited in Buchman and Floden, 1989, p. 247)

In the present research, a grounded theory approach was used as the methodology for the data collection and analysis. Since experiencing psychiatric illness can be conceived of as a social act (Goffman, 1961), social constructionism and symbolic interactionism were used to guide identification and theorising of the social and contextual factors a play in a participant’s data. Social constructionism provides a theoretical orientation (Burr, 1995) to underpin theoretical considerations such as symbolic interactionism. Narrative analysis was also used to analyse the biographical nature of the women’s stories. Therefore, the theories utilised in present research are grounded theory, social constructionism, symbolic interactionism and narrative analysis. The following sections outline each of these theoretical approaches.

4.3.1 Grounded theory

Barney Glaser and Anselm Strauss’s grounded theory, developed in the late 1960s, gives us, according to Crooks (2001, p. 2), “a picture of what people do, what their prime concerns are, and how they deal with these concerns.” A grounded approach is one where you do not have a hypothesis that you test, but a subject area that you are interested in learning about from which you can generate a theory from your findings. Its aim is, using an inductive approach, to develop theory about a phenomenon directly from the data. To do this it

employs a set of systematic procedures. Concepts are refined into a coherent theory by use of a constant comparative method with which the researcher generates and refines thematic coding as the data collection is undertaken rather than only after the data collection phase. Grounded approaches have a strong track record in the social sciences, including in the study of women's health issues, eg, mothering while using crack cocaine (Kearney, Murphy & Rosenbaum, 1994) and psychiatric illness and employment (Tse & Yeats, 2002.) A grounded orientation has been used in nursing research since the 1970s (Backman & Kyngas 1999) and in Aotearoa/New Zealand studies on women (Barrington & Gray, 1981: Hancock, 1981; Hill, 1979.) It is different from many methodological approaches because data collection and analysis are indivisible from the beginning (Charmaz, 2002; Holloway & Wheeler, 1996; Wainwright, 1994) and a theory about collective social patternings is generated that is seen as being 'grounded' in the data. These characteristics make grounded theory a useful foundation for the present study.

4.3.2 Symbolic interactionism

Grounded theory is widely held to be founded out of symbolic interactionist orientations which view the 'self' as being constantly re/negotiated self-reflexively and dialogically in contexts that are open to contention and reinterpretation through constant symbolic exchange (Kearney, Murphy, & Rosenbaum, 1994.) In relation to illness, Frank (1995) makes the important observation that there is a social aspect to people's narratives of illness for people cannot form their narratives by themselves. As Kowalski (2001, p. 179) says "you have to let people influence you. We're a tribal kind of creature. We learn from stories." People can only form narratives of their experience of illness through internalised expectations of what people believe illness is and how it is currently treated and what people value in terms of knowledge and expect in terms of story from them (Frank, 1995.) Like Malinowski (1923), Frank believes that contextual and dialogical factors were bound together indivisibly in the comprehension of people's utterances. This belief matches Herbert

Blumer's theoretical development of symbolic interaction – shared meaning through verbal and non-verbal communication (Blumer, 1969; LaRossa & Reitzes, 1993.)

Symbolic interaction was developed by Herbert Blumer (Blumer, 1969) and his colleagues at the University of Chicago in the United States and drew on the work of George Herbert Mead (Mead & Morris, 1934), Charles Cooley (Cooley, 1902), John Dewey (Dewey, 1894) and William Issac Thomas (Thomas, 1923.) It was developed with the assistance of many female sociologists at the University of Chicago, though their input is largely ignored in histories of the theory (Deegan, 1987, 1995.) That aside, the theory operates from the assumption that individuals mediate their sense of self and the world by the process of interpretation of their experiences with others (Blumer, 1969), and that the key mechanism for this is interpretation of symbols of meaning most commonly exchanged through language. The world is seen as symbolic as well as ontologically 'real,' or, as a social constructionist might put it, reality is not a stable known but a contestable result of human interaction (Pilgrim & Rogers, 1999.)

Social interaction is crucial for the development of meaning (symbolism). As Habermas (1992, p. 43) said "subjects ... live off grammatically projected interconnections of meaning ... the structure that forges conditions of possibility." Biological 'truths' are seen as always being mediated by language and culture (Sedgwick, 1982.) Social interaction and language, being the dramatic act of negotiating meaning and thereby re/defining 'reality' (Berger & Kellner, 1974; Brissett & Edgely, 1974), is seen as constructing an individual's sense of self. Poster (1990, p. 11) notes that "[persons] are constituted in acts and structures of communication" – in other words dialogically. Through the exchange and contestation and constant reinterpretation of meanings caused by social interaction, experiences occur that the individual then reflects upon and meanings derived from that are incorporated into her-or himself to be brought out and modified at the next social interaction (whether it be conversation, reading a book, or watching television, for example) (Jacob, 1987.) Both social and psychological processes are at play in this dialogical and self-reflexive production of

symbolic reality aside from ontological reality. What Blumer (1969) makes clear is that behaviour is not the outward expression of the individual's beliefs and meaning-making but an outward expression of the forces at play, those "factors which play on the individual" (p. 83) – sometimes non-complementary and conflictual – in terms of any given situation in which a person socially interacts with other human beings. Behaviour is not an expression of sound reflection and steady conceptualizing. It is meaning-making in action and social contestation at the micro-level of power, shaped by macro-level hegemonic forces such as culturally determined beliefs about age, sexuality, gender, ability and religiosity. George Herbert Mead termed the commonly held beliefs and attitudes of the wider society the 'generalized other' and sees the individual as responding to this generalized other by forming a 'self' in relationship to it (Mead & Morris, 1934.) Nisbet described the five core attitudes towards the generalized other as exchange, cooperation, conformity, coercion and conflict (1970.) Self-concept in this way of viewing human beings is the result of all the person's thoughts about themselves as an object operating and operated upon in the social realm. It is a theory about oneself (Epstein, 1973) or it is an idea of oneself, what Cooley termed 'a looking glass self' (McIntyre, 2006; Shaffer, 2005; Starks, 2007.)

For the purposes of this study, the construction of the individual through social interaction and self reflexivity (Blumer, 1969) – and the relationship of the individual to society and the State (as culturally shaped and defined by power at a particular time in history) – are the predominant theoretical frames to be used in data analysis. Conditioning by society and its influence on the meaning-making and self-development of each individual in the present research will be considered central, because psychiatric illness is a social marker (Goffman, 1961) and cannot exist without various 'actors'⁴¹ and hegemonic beliefs that operate to create a standard plot that the participant, once diagnosed/labelled will be expected to take part in. Their experience from diagnosis through to treatment and on to

⁴¹ To Talbot Parsons (1951) and Goffman (1956, 1959), amongst others, we can be viewed dramaturgically as actors on a stage (Adler & Adler, 1997; Harre, 1993; Mitchell, 1978) constructing reality and identity through interaction and meaning-making. We have back stories that inter-locutors know little about but which drive our sense of agency and construction of self.

recovery which has been captured by the data and their eventual return to work can be seen to be a social act and a ritual of return for each of the participants (Pilgrim & Rogers, 1999; Usher & Edwards, 1998.) Cohen, Manion and Morrison (2000, p. 26) see societies as being made up of interacting individuals: “people are constantly undergoing change in interaction and society is changing through interaction.” Meaning is seen as constantly evolving and variable depending on the individual person and their interactions with others, but nevertheless systematic in terms of social movements and cultural epochs. In effect, the very ‘self’ itself is a system of ideas and language that is constantly modified through the validation or censure that occurs as one interacts with other people (Becker, 1974.)

Symbolic interactionism has a research tradition in psychiatric illness through Goffman’s research into patient roles (Coulter, 1979; Goffman, 1961) and the extension of this work by Braginsky (Braginsky, Braginsky & Ring, 1969.) It has been used to study professionalization in psychiatric treatment in the work of Hughes in 1971, Emerson and Pollner in 1975 and Goldie in 1977, and to look at maintenance of the role of deviant in the interactions between patient, professional and significant others in the work of Scott in 1973 (Pilgrim & Rogers, 1999.) Goffman was interested in what he termed ‘degradation rituals’ (Goffman, 1961) such as labelling and the removal of personal possessions and clothes, and Bean (1980) compared labelling theory in the treatment of criminals and psychiatric patients as rule breakers (Pilgrim & Rogers, 1999.) Sheppard in 1990 undertook a comparative study of the communicative acts of psychiatric social workers and psychiatric nurses (Sheppard, 1991.). Sheppard found that the theoretical frames of reference and epistemologies (bodies of knowledge) under which they oriented their work – social science for social workers and medicine for nurses – accounted for attitude and behaviour differences between the two groups (Holliman, Dziegielewski & Teare, 2003.)

Symbolic interactionism has been accused of seeing the individual and society as indistinguishable since they are two parts of a symbolically interactive process (Meltzer, Petras & Reynolds, 1975.) ‘Self’ becomes the personal construct of a self-reflecting

individual operating in society and 'roles' are the public socially circumscribed ways in which an individual operates. Some criticize the view of the human 'self' as only a construct rather than an ontological reality (Meltzer, Petras & Reynolds, 1975.) They see this as meaning that the individual can never have agency because they are trapped in a symbolic structure where the personal is a myth. But when looking at symbolic interactionism as a process rather than a structure it is clear that the individual has agency. It is just that agential thinking with regard to the 'self' will not be created in a vacuum but is itself symbolically constructed by counter-hegemonic discourses at play in the social world of others with whom an individual interacts. There will always be a genealogy of any agential counter-hegemonic idea traceable back to the thinking of others (Foucault, 1977b.) Only the brain processes that interpret experience and modify instinct into role taking can be said to 'ontologically' exist, though this might be argued against by postmodernists who view the physical sciences as mere construction. Before and more so after reading *Fashionable Nonsense* [aka *Intellectual Impostures*] by Alan Sokal and Jean Bricmont (1998), the postmodernist view of the science is not one that I share. I also have no problem in seeing the 'self' as a social construction since I have been Buddhist since age 14 and such thinking fits with Buddhist philosophy on the nature of 'reality.' The 'self' has no less meaning and purpose in an individual's life whether it ontologically exists or is a social construct.

For the reasons given in the section above, the use of symbolic interaction to guide and underpin the research process of interviewing women who have been diagnosed with a mental illness in a particular country at a particular historical juncture and in particular cultural milieu can be deemed entirely appropriate.

4.3.3 Social constructionism

Rose (1999, p. 1) notes that "our subjectivities are, "...intensely governed" and that "thoughts, feelings and actions may appear as the very fabric and constitution of the intimate self, but they are socially organised and managed." Social constructionism has been a

widely used theoretical frame for sociological studies of social problems and medical issues (Pilgrim & Rogers, 1999) and much of *doing* sociology is in effect *doing* social constructionism. The factual status of the 'problem' or issue is queried and its socio-cultural and politico-economic status is examined. In 1966, Berger and Lickmann wrote *The Social Construction of Reality* in which they outlined a sociological theory of how reality is perceived and created (Berger & Lickmann, 1966.) Reality is seen as a continuously re-created phenomenon that is produced through the interpretations and agreements of human beings. As Lundberg, Schrag, Larsen and Catton, (1963, p. 171) had already noted: "*a normative order* specifying what human beings should or should not think, say, or do under given circumstances underlies or emerges from all human relationships ... culture provides the *rules* that define the *roles* that make the *relationships* that constitute the *group*." Indeed, it can also be said that groups provide the relationships that define the roles that atrophy (through lack of contestation) into rules. Social interactions are required constantly to maintain and evolve what is socially agreed upon to be 'normative' or 'reality.' As Deutscher notes:

I can see no basic difference in defining, say, a delinquent boy, in terms of the devil, the genes, or mental illness. The shift in words tends only to make us more condescending, more tolerant, more "understanding" of the deviant behavior. (1973, p.248)

One would have to argue that such different perceptions of the boy's 'deviant' behavior would in fact have a huge impact on the boy himself and on society's sense of safety in the face of young male delinquency. However, Deutscher is arguing about theory and not about any delinquent boy in question. Deutscher's argument is against the hardening of such reductions or constructions into 'common sense' truths. It is anti-essentialist. Since the focus of the present research is psychiatric illness, it is important to employ a theoretical perspective that explores the meaning-making and the impact of shared meanings upon people in society who are labeled as psychiatrically ill, rather than seeking out any 'common sense' truths.

Perceptions of reality according to a social constructionist view need to be negotiated and contested between individuals and groups in a context-specific way, ie, constrained within “the ritual order of social life” (Branaman, 1997, p. *lxiii*.) What can be seen when contestation does not occur anymore is that notions created through this social interaction could be perceived to be taken-for-granted truths because they have become long-standing, seldom disagreed upon ‘truths’. However, everything is really socially invented, even the social self of human beings that regulates and codifies the behaviour of the biological self through social interaction (Branaman, 1997.) According to symbolic interactionism and dramaturgy, the social world is constructed through interaction and therefore the influence of others on the meaning-making of participants in this study is important, for the self only exists through ‘consensual validation” (Brissett & Edgley, 1974.) A diminution of the self – a stigmatisation – occurs when an honourable validation of the self cannot be agreed upon, for example, when ritual norms in society (such as the requisite for ‘sanity’ and ‘sane behaviour’) are violated by ‘insanity’.)

Ways of seeing the world are subject to cultural and historical specificity (Burr, 1995; Cosgrove, 2000.) Biological sex might be seen to be biologically ‘real’ (though intersex people might refute this) but gender, to a social constructionist, is socially constructed through interpretation and agreement at different times in history and in different cultural contexts and therefore needs to be reinforced against the threat of alternative constructions from the mainstream construct (Cosgrove, 2000.) As Antonio Gramsci argued (1971, 1992) in his theory of ‘hegemony,’ certain cultures will have the dominant hegemonic view over other cultures in terms of what is seen as ‘common sense’⁴² (Marx’s ‘false consciousness’) due to their superior power in asserting and maintaining their constructs (Ives, 2004.) It is the job of a viewpoint based in awareness of Gramscian hegemonic theory, and using the theoretical paradigm of social constructionism, to take a critical view of what is seen to be ‘truth’ and ‘real’ in society, and indeed of what constitutes the ‘self’ (Burr, 1995.) Social

⁴² For example the dominant notion of childhood ending at 16 which makes holders of this hegemonic view rail in disgust at the ‘child brides’ in Romania from Romani gypsy families.

constructionism sees individuals as creating meanings in dialectical interaction with others in society and that these meanings may come to constitute worldviews, and even dominant worldviews (hegemonies), if sufficient individuals are in agreement. Such hegemonies become invisible to the naked 'I' – and are incorporated into the self's belief system – and can only be made overt through social constructionist and symbolic interactionist interpretations.

Juliet Butler in *Gender Trouble* makes the point that “identity is performatively constituted by the very ‘expressions’ that are said to be its results” (1990, p. 25.) In her view, gender is interactively constructed rather than biologically endowed. Only by acting the part of female or male, feminine or masculine, do we in fact ‘become’ them. They have to be social agreed upon and become hegemonic, though the minority can disrupt them through subversive acts. Butler attacks the central premise of feminism as being imperialist and Western, and sees patriarchy as a construction and the universality of woman as an unhelpful constraint into which minorities have been forced. Butler sees discourses as regulating what sex, gender and desire ‘are’ through repeated ‘enactments.’ Everything is discursively produced and, for Butler, performativity is the key concept. We ‘do’ gender; we ‘do’ all agreed upon divisions, such as female and male, heterosexual and gay. We are not them, they are only doings – common characteristics developed through performativity and discourse. Certain performances – doings and sayings – have taken hold as mainstream at any specific historical and socio-economic time and in any specific geographical space, and they become hegemonic for that time. Even sub-cultures such as the queer community have their own hegemonies, for power is everywhere and is the basic currency of discourse, despite being dressed up as knowledge, common sense or fact. This view is anti-essentialist, A purpose of this research is to unpack the taken-for-granted hegemonic as well as the subversive minority notions of the research participants.

The subjectivity of identity is a crucial anti-essentialist idea behind the data analysis in this study. The basic premise upon which the data analysis operates, is of ‘self’ being

constructed through symbolic interaction and related in this study to the researcher through biographical and discursive acts, rather than 'self' being seen as trait (Peavy, 1995.) All psychological conditions – whether defined as 'sane' or 'insane' – are “grounded in a social matrix” (Berger & Kellner, 1974, p. 231). Self is divided by George Herbert Mead into 'I' - a version of the Kantian true self that is spontaneous and expressive and cannot be perceived by a person - and 'me', the censor, the aware part of the self that reflexively is the sum of all social responses to the 'I' and the contexts in which the 'I' has been operating (Mitchell, 1978.) It is this kind of 'self' that is used as the theoretical basis for data examination. In a sense, sociology views the self as existing in interaction socially (where power is always a dynamic) and through the exchange of agreed upon symbols that may be contested at times. Rather than the Cartesian notion of 'I think therefore I am', the notion of 'I interact therefore I am and thereby I know what I think' is the underlying premise of the present research.

Participants are seen as using their stories to articulate their experiences for “meaning is apprehended by looking back over a temporal process: it is generated in the narrative” (Turner, 1982, p. 76.) As symbolic heroes, they are able to construct a view of their 'self' that is more than that of an ontological body and brain afflicted by a psychiatric disorder. Stories provide a sense of personhood to illness (Ballard, 1994) and analysis of them can uncover the ways in which story-tellers resolve the existential tensions they experience in the multiplicity of roles in which they function in society as a sick person (Frank, 1995; Parsons, 1951⁴³.) They are also making meaning of their stories based on the present-day context they find themselves in as a story-teller (Bujold, 2004; Frank, 1995; Mitchell, 1978; Taylor & Bogden, 1998.) Individuals may feel themselves to be 'authors' of their own stories but, in fact, they will be deeply influenced by the authoring of 'reality' that

⁴³ Talbot Parsons, a functionalist sociologist, showed through research into doctor-patient relationships that the sick role is functionally required to maintain social order since such a role legitimates withdrawal from vocational and social obligations. From a functionalist perspective, adopting, or being coerced into adopting, the sick role means that the individual lessens the impact of their illness on the social system in which they operate as a member. It removes personal responsibility for the illness while also requiring the individual in the sick role to seek the attentions of a socially-sanctioned professional, such as a psychiatrist or general practitioner (GP). A symbolic interactionist perspective would expand this functionalist view of the sick role to show how an individual negotiates with all significant others in their social system in order to construct a view of how sick they are and it would also examine how redemptive certain symbolic acts might be to the sick person's functional selfhood in society.

comes from dominant ideologies (Burr, 1995; Roberts, 2002.) Sociologically, identity is constructed through language and culture (Cosgrove, 2000; Lynch, 1997.). Culture creates grand narratives that inform the individual narratives of meaning-makers (Roberts, 2002.) Neither can exist without discourse. Certainly, power can be exercised through physical brute force (that, nevertheless, is ideologically and thereby linguistically based) but it can be exercised also through language since we are socially constructed by the discursive interactions that form and define 'reality' (Pickering, 2000) – both restricting the individual and allowing for agency to disrupt or defy social constraints.

The present research attempts to uncover the ways in which knowledge about women's experience of psychiatric illness and work are socially constructed and to unpack the dominant ideologies behind these constructions (Roberts, 2002; Woollett & Phoenix, 1997) as well as the individual constructions of the interlocutor, bound as they are in a constant exchange of symbols with others in order to create, maintain and reorder not only meaning but also their actual 'self' (Pilgrim & Rogers, 1999.) There are different ways in which a social constructionist approach can focus on data. Social forces that define the way a phenomenon is experienced can be unpacked. Alternatively, in a more Foucauldian approach, the language and symbols used in the data can be examined. Then again, the influence of professionals upon knowledge creation in a certain field can be evaluated (Pilgrim & Rogers, 1999.) None of these approaches needs to be mutually exclusive and all are used in the data analysis in the present research.

4.3.4 Narrative discourse analysis

The aim of the present research is to situate the participants and contextualise them politically and culturally so that the social reasons behind their relating of their lives can be revealed. A narrative discourse analysis approach fits with a social constructionist orientation and assists in this process. Communicative acts are central to symbolic interaction and

social constructionism and narrative discourse analysis helps with a detailed analysis of the women's comments and how these comments reflect their positionality in terms of hegemonic power, discursive disruption and contestation of power, as well as the dynamics of interaction and the performativity of sharing memories. Narrative discourse analysis can interrogate communicative acts and utterances to explore how the subjects of this study communicate their 'stories' and views in relation to the wider social world that, daily, they negotiate and reflexively process as they construct and reconstruct their view of 'self'.

Discourse analysis was coined as a phrase by Zelig Harris in 1952 (Markee, 2000.) It traditionally comprises several different approaches to analyzing written, spoken or signed language use and looks at conversations, texts and any kind of communicative event. In the social sciences, discourse analysis is particularly involved with natural communicative acts rather than written or contrived texts. Norman Fairclough describes discourse in different ways (including "instances of sociocultural practice" (1995, p. 2), or what one might also term symbolic interaction), that require an examination of the context or meaning above the grammatical level in terms of language production and social interaction through language.

Discourse can be seen simply as any spoken, written or signed (as in New Zealand Sign Language) communication. It can also be seen as the underlying assumptions, meanings and beliefs behind the signs and symbols that are exchanged and contested through communication. Some discourses are seen as hegemonic because they are dominant in society. All discourse is embedded in social, economic and political contexts from which it cannot be divorced (Blommaert, 2005; Gee, 2005; Jaworski & Coupland 2005; Johnstone, 2002.) Looking at discourse enables a researcher to explore the relationships between communication acts, structural components of society and individual agency. The reproduction of social, political and economic power through the exercise of discourses is the primary focus of critical discourse analysis. A critical discourse analysis approach sees discourse as a resource to which there is unequal access.

Narrative is a constructive format given to an individual's communication about themselves to another person. The narrator can shape their 'story' so that the recipient of their communication sees their point of view or views their communication in a particular way. As Berger says, "never again should a single story be told as if it is the only one" (1976, Preface.) With each telling the narrative is reshaped – a new 'truth' is crafted - according to the context in which it is being heard or read to reflect some new information about life in human society that the interlocutor has taken on board since the last telling (Cosgrove, 2000; Greene, 1995; Morgan, 2000.)

Narrative can also be defined as an underlying sociolinguistic patterning, that an individual may not even be aware they are employing, that fits in with dominant views of the world and reality. This is because the power of discourse is seen by many theorists as being controlled institutionally (Fairclough, 1995 & 2001.) There are key 'truths' and beliefs (dominant discourses, ideologies and hegemonies) in a culture society or nation that are in fact shared narratives (Gordon & Alexander, 1996; Roberts, 2002.) Ideologies and hegemonies inform narrative analysis when it is used as a tool for unpacking the hermeneutic, sense making qualities of an individual or group of individuals. Dominant ideologies shape an individual's perceptions and narrative analysis can examine the individual's response to these shapings and the meaning-making of them (Arthur, 2006; Watson, 2006.) Narrative analysis can be wide ranging and fit a number of different methodologies (Josselson & Leiblich, 1993.) A social constructionist approach using narrative analysis can also take a clear look at what is absent in the communicator's meaning-making since a communicator is seen as having access to some discourse and not others due to their social-cultural constraints. It is in this way of looking at discourse that silences become meaningful.

Aristotle's *Poetics* outlined what narratives were from a structural point of view and this was adopted by modernists and persists in mainstream Western culture today (Gordon & Alexander, 1996.) While many theorists convey narrative as linear, postmodernists have

reframed narratives as having fragmented time, little unity and no distinct order (Lather & Smithies, 1997.) Virginia Woolf, who herself experienced mental health problems and ultimately committed suicide, was an early exponent of this postmodern fracturing in her writing (Caughie, 1991.) The Aristotlean sense of narrative being linear nevertheless prevails in everyday thinking and narratives can be seen to be structured for the retelling of events in ways that most frequently involve a clear progression of time, a clear plot and a style involving a clear beginning, middle and an end (Connelly & Clandinin, 2000; Kermode, 2000; Labov, 1972; Ricoeur, 1984; White, 1980.) It is a process of meaning making that may not convey the ontological 'reality' of an event but rather the discursive sense making of the individual telling the story and, in this sense, narrative analysis can provide rich interpretation of research data and unpack the meaning behind how a story is told and what is said. As McPhee says:

Memory has no organic sense of time. We organize our lives around time through external narratives, but the brain itself doesn't use time structurally. We really just delude ourselves into thinking we have an ordered past. (2004, p. 149)

MacIntyre (1985) sees Aristotlean narrative communication approaches as providing 'sense' to events that may not be fully intelligible. In a sense, the ordering processes and self justifications of the heroic 'self' in any autobiographical story indicate that narrative development is a self-soothing tool to assist the self in coping with disordered, sometimes disturbing and often incomplete events. Narrative creation provides an ethical evaluation of an event and a sense-making emotional accommodation of life's trials and tribulations. It should be noted that while a story might be autobiographical it, in fact, has many unseen authors as different discourses become assimilated by the narrator through their symbolic interaction with a socially constructed world. MacIntyre sees us as co-authors of our narratives since our own story fits inside the contextual stories of others:

We are also (at the very least) the coauthors of our own narratives – I can only answer the question 'What am I to do?' if I can answer the prior question 'Of what story or stories do I find myself a part?' (1985, p. 216)

This is where the idea of narratives clearly meets symbolic interactionism, since narratives are shown to be co-created between people and authored by the individual account-reteller

with reference to the audience receiving the narratives and the groups and individuals with which the individual interacts (ie, the context or milieu in which they abide) (Cosgrove, 2000.)

In the present research, ideas of narrative are used both in a linear and uncontextualised way (Ezzy, 2002), as stories with a beginning, middle and an end⁴⁴, and in a dramaturgical way (Goffman, 1956, 1959) in terms of the actors and plots (plot being one of Aristotle's⁴⁵ key components of narrative.) Looking at the different actors and the various contexts in the participants' stories can produce a sense of 'ways of seeing things' that is useful in the data analysis phase of a research project. As this section has also shown, life experience is shaped by narrativity so that it is storied and constructed to convey and express the personal readings attached to events rather than conveying a 'realistic' account of life events (Ezzy, 2002; Josselson & Leiblich, 1993.) Understanding this helps the present research to conceptualise the motivations and belief-systems at work behind the events described by the participants. It can help give voice to often non-hegemonic discourses which are seldom heard in society. As a methodological tool, narrative discourse analysis can analyse the ways in which 'truths' and beliefs about psychiatric illness and work/career, as shared narratives – whether ontologically 'real' or not – underpin the women's stories and influence their belief system when it comes to sharing their own lives with a researcher. A narrative approach to thematic analysis allows for a critical evaluation of ontological and epistemological issues, rather than a non-critical one. For example, the story told by the participant is not seen as 'truth' but is critiqued in light of what purpose might be served by a participant shaping a story to give it more of tidy ending or to present themselves or others in a particular light. How the life story is told is more crucial than the linear recounting of events. Plot, when critically evaluated as construction, delivers rich data findings beyond mere biographical description. No 'truth' can be found in the findings but a discussion on the categories produced by the data collection can be generated via the theoretical lenses

⁴⁴ Elements of the linear 'beginning, middle and end' type of narrative were identifiable in aspects of the women's stories, for example, in the pre-diagnosis and post-diagnosis delineation the participants made between 'madness' and 'mental illness'.

⁴⁵ More on Aristotlean views of narrative can be found in the part of this thesis that looks at theoretical approaches used to analyse the data.

chosen for the study. This allows for complexity, contestation and contradiction in the story-telling by the researcher about the participants' stories, rather than plain descriptive findings that seek simple truths and often accept dominant paradigms uncritically (for example, uncritical acceptance of the 'medical model' in psychiatric illness research.)

4.4 Considerations

4.4.1 Researcher bias

In a study that attempts to understand the meaning-making of a group of women talking about their lives, the meta-meaning making of the researcher in identifying codes and themes must be understood (Ballard, 1994.) This can be a weakness, even when expressly stated by the researcher, unless there is a sufficiently strong theoretical lens and paradigmatic frame through which the research data are viewed. In the case of this study, the positionality of the researcher and the theoretical tools used to make meaning of the data are expressly stated. They are also well suited to the research undertaken since the researcher brings empathetic regard for the research participants by having had her own experiences of psychiatric illness.⁴⁶ Research of service user/'consumer' experiences by service user/'consumer' researchers is a method that has been well tested in the area of health and medicine. Furthermore, theoretical tools such as narrative analysis are suited to the type of topic being researched, namely life stories, and also ensure that the researcher keeps a methodological distance from imposing her position uncritically upon the data. The researcher takes on a reflexive, conversational approach with regard to the data and this allows for clarification of any assumptions that are made. In qualitative study, the theoretical tools being used also help to shape the meaning derived from the data and help guard against assumptions on the part of the researcher. In this way the methodology helps to direct the researcher and keep bias at bay.

⁴⁶ This empathetic regard does not preclude the researcher being able to be 'comfortable' with results not matching her own personal experiences of psychiatric illness, mental health services and workplace issues. This was in fact the case in this piece of research.

4.4.2 Participant wellness

All but one of the women in the study was not significantly psychiatrically unwell at the time of interview, though some were struggling with anxiety, depression and eating disorders. As Luhrmann (2000, p. 13) notes “firsthand narratives do not always help ... because the author (now recovered) seems either too sane to have been ill.” While this might be considered a weakness in the study, it can, in fact, lead to the production of different data. The majority of the women were not seriously unwell. The stipulation that all had been diagnosed by a medical professional as one of the bases for inclusion in the study meant that most of the women had experienced significant amounts of wellness in the recent past for a variety of reasons to be found in the data. This was a study about women’s career development and their stories about how being given the diagnosis of psychiatric illness affected them socially and vocationally, rather than a study of women’s insanity and how it is expressed through autobiography.

Volunteers can add a bias due to their volunteer status (Katzner, Cook & Crouch, 1991.) It may have been that a certain level of wellness was required for participants to feel suitably safe and able to cope with an interview process. It also may have been quite a different study if only women who were actively unwell had volunteered. That is not to say that the women were all in remission from their symptoms. They were not, and, more importantly, the point of the interviews was to gather life stories and not select women based on active illness or a lack of it. For the majority, their illness was still ongoing, but active present unwellness at the time of the interviews did not influence their narratives, except for one woman. Nevertheless she was cogent and her story was clear, despite her verbosity and high energy during the interview process. No selection was made based on the sanity or insanity of the individual but it may well be that the more well the woman, the more likely she was to have attended the *Balance* conference or been out in the world to such a degree that she came across the study and opted herself into it as a volunteer. Again, this only means

that this is not a story of women who were predominantly unwell at the time of data collection.

4.4.3 Researching women

It has been especially important to protect the anonymity of the women since discrimination and stigma could result from their identification due to the subject matter of their stories (for example, rape) and the fact that several of the women were also lesbian or bisexual. Therefore, any opportunity to trace a woman's story by looking at a range of participants' comments, even with synonyms attached, has been avoided. This was a requirement of the University of Canterbury Human Ethics Committee but it did also detract from several women's agency since they would have preferred to have been named in the thesis and felt that they were somehow hiding as though ashamed and did not want this. In terms of agency, total authorial authority was given to the woman in terms of changing any detail and adding or deleting any words from their transcripts as they saw fit. It should also be noted that all of the women in the present research were offered a copy of their finalised transcripts to keep and most wanted them and were given them. As has been noted above, they all had the opportunity to amend their transcripts at the draft stage, but the final transcripts were requested by them for a variety of reasons including the fact that some of the women felt having a typed record of their experience would be useful to show to others, particularly family members, to help others gain more insight into their experience. It may have been that the document – typed and official-looking – helped their testimony have more power in relation to their significant others and family members. Because most of these women do have their transcripts, in this way they do remain whole textually, outside the pages of this thesis.

There must necessarily be power dynamics in any researcher-researched dyad at the interview stage (Burns, 2003; Lather, 1991) and at the analysis stage when the self-reflexivity of the researcher becomes critical to not disempowering the women textually and

not rendering inauthentic themes from their texts (Del Busso, 2007.) Women as embodied participants and as textual shapings must be protected from methodological violence by the researcher. By placing themselves into the text as another voice among the voices of the participants, researchers can disempower themselves profitably through a reduction of methodological omnipotence (Rice, 2009.) Making theoretical closure only as important the personal fulfilment of the participants (through their ability to ventilate their experiences and have their lives validated in the interview and other contact the researcher has with them) helps to balance the power in the research context and guard against a plundering of the women's lives for data and academic achievement by the researcher.

CHAPTER FIVE

Method

This chapter presents the methods adopted for the present research. It outlines the research tools used and the phases of the research undertaken.

5.1 An overview of the research phases

The research phases for the present research involved designing the study and gaining ethical approval, attracting participants, and then negotiating through an initial phone call interview dates, times and locations for the interviews and informing participants of the style of interviews and their rights as a participant. After that it involved meeting the participants and giving them written information on the study (see Appendix A) and a consent form (see Appendix B) to peruse and time to decide if they wished to sign it. It then involved pre-audio-taping protocols such as reiterating that the audiotapes would be destroyed once participants had approved the final transcript, that they could withdraw from the study at any point and that all identifying features would be removed from the transcripts. Also the women were invited to choose a pseudonym based on a flower's name at this point. Then the audio-taping of the interviews was undertaken using a semi-structured approach. After this the transcripts were prepared and sent to the participants to be checked and amended and, once returned, they were finalized and a copy sent to the participant if she required a copy, as many did.

Literature reviewing began once data analysis had started and themes had been identified. The literature review was shaped by the data. Data analysis was completed using the theoretical lenses that had been identified as useful to the study, namely social constructionism, symbolic interactionism and narrative analysis. Then the project began to

be written up and literature was checked frequently to ensure that new studies were included in the literature review. Supervisors were the only people to see the transcripts in their entirety and never knew the names of the participants or saw any other identifying features. They helped to advise and clarify methodological issues in the present research, particularly by advising on the research design phase and being a sounding board during the early data analysis phase of preliminary coding.

5.2 Ethical considerations

Prior to interviewing participants, I applied for and was granted ethics approval from the University of Canterbury's Human Ethics Committee. Participation in the present research was to be voluntary, informed consent was to be sought and the Human Ethics Committee approved the study as not being detrimental to participants. Measures were to be taken to ensure confidentiality and anonymity. Interview audiotapes were to be destroyed immediately after transcription and all transcribed material was kept in a secure restricted-access location. Participants' anonymity would be assured by each participant choosing a pseudonym (Glesne & Peshkin, 1993; Tolich & Davidson, 1995) relating to flora, for example, a daisy. An information sheet would provide written information on the study and a signed written informed consent would be sought from the participant after verbal discussion at the beginning of the interview process (Glesne & Peshkin, 1993; Holloway & Wheeler 1996; Seaman 1987; Yin, 1994.)

The Human Ethics Committee's application's approval was mainly dependent upon assuring the confidentiality of collected data, anonymity of participants in the published research and the ability of the participants to withdraw from the study at any time. I was approved to store the data in a locked cabinet and use a password to access research data in my computer. I suggested the use of pseudonyms to avoid exposure of participants' identities and this was also approved. I also ensured anonymity and confidentiality by altering any identifying features, for examples, the names of cities or corporations. My

consent form and information sheet were accepted as meeting ethics approval and I also promised to destroy all audio-tapes and personal information in an appropriate manner before the end of the present research.

I was required to make clear to my participants, through my information sheet, what forms of dissemination might be used for the information discovered in the present research. This I did prior to the interviews and in writing. I indicated that the results of the research might be published in journal articles or in conference presentations, as well as in the final thesis, but that participants could be assured of complete confidentiality of data gathered in this investigation and anonymity in any written material. I also indicated that a copy of the thesis would be placed in the Library of the University of Canterbury and the then School of Education Library (now the College of Education Library) at the University of Canterbury and that people would be able to use it for future research and for assignments in areas such as social work, psychology, education and sociology. I also informed participants that the thesis might be published as a book (in which case a copy would be available from the Mental Health Education and Resource Centre library in Christchurch and other mental health groups and libraries around New Zealand) and that a booklet might be produced for employers and employees and that organizations might ask to read it to help them in their work in mental health and employment. Such clarity on dissemination issues satisfied ethical considerations on dissemination in the eyes of the Human Ethics Committee of the University of Canterbury.

5.3 Gaining access

5.3.1 Attracting participant interest

Snowballing sampling, one of the most common qualitative sampling methods (Priscilla, Robinson & Tolley, 2004), assists the researcher in creating a research sample for their study by using the participants themselves to introduce the researcher to the next participant

(Lofland & Lofland, 1995.) In this way, participants who might be hard to access can be reached (Priscilla, Robinson & Tolley, 2004.) In the present study, all but two of the participants were accessed through snowball sampling. Participants were recruited in four distinct ways, two of which involved the snowballing method directly (with participants recommending my next interviewee), one of which used indirect snowballing due to self-referral by prospective participants upon hearing about the research from others, and the last of which involved a non-snowballing 'happenstance' style method (where women happened to ask me about my research, told me that they could tell me a story about their experience, and were then invited to participate). So, to sum up, the participants can be seen to have been attracted:

- from an initial selected interviewee
- at the *2005 Balance Conference* in • tautahi/Christchurch, Aotearoa/New Zealand
- by word of mouth
- through 'happenstance'

Snowballing from an initial selected interviewee

The initial interviewee was chosen because she had taken part in a BA (Hons) single case study research project of mine on lesbian career development and fitted the participant profile required for the research in that she was a woman living permanently in Aotearoa/New Zealand who had experience of living with psychiatric illness. The name she chose as her pseudonym was Nikau. During her interview she suggested I interview a woman known to her. This next woman suggested another woman and so on. The participants generated by this recruitment method were: Nikau, Wattle, Jasmine, Daisy and Poppy. They were all interviewed face-to-face.

Snowballing via an attendee at the 2005 Balance New Zealand Conference

Balance NZ⁴⁷ is a New Zealand organization for people with experience of bipolar disorder which also has people affiliated to it who have depression. At the *2005 Balance New Zealand Conference* (November 11-13, 2005), participants received a flyer written by me asking for interested participants (see Appendix D.) The information provided on the flyer was both handed out and read out as a notice at the conference. One woman at the conference was initially interviewed and led, through snowballing, to introductions to three more women, not all of whom had bipolar disorder. All of these women, coming from the North Island, were interviewed by telephone except one who came down to • tautahi/Christchurch to participate in another research project and therefore was able to be interviewed face-to-face. The participants generated by this recruitment method were: Catnip, Lily, Hibiscus and Hebe.

Word of mouth

Another recruitment method occurred when participants approached me after hearing about the research from other participants and self-referred themselves to the research project. The participants generated by this recruitment method were: Marigold, Pohutukawa, Hawthorne and Manuka. All of these women were interviewed face-to-face.

'Happenstance'

Two other women were also recruited through a 'happenstance' type method. When I was asked what my research was about, sometimes an enquirer might say something along the

⁴⁷ Balance NZ - Bipolar and Depression Network was founded in 1996 with Michael Wiltshire and Julia Christie organising and convening the inaugural conference of representatives from around New Zealand. The first national hui was held in Wellington. Meetings and training days have been held on an annual basis since then at Quaker Acres, Wanganui and in other regions. Membership of Balance NZ is extended to individuals, families, peer support groups, non-government organisations, and health professionals. Balance NZ is a national network set up and operated by consumers to help members who have experienced mood disorders, primarily bipolar disorder and depression, to cope positively with their condition. It also works closely with family members and acts as the umbrella group for a number of regional bipolar and depression support groups (*Balance Newsletter* Issue 8, Nov, 2005, p. 1.)

lines of “I could tell you a story about my experience ...” At this point I would invite them to take part in the research if they wished. The participants generated by this recruitment method were: Celmestia and Rose. Both women were interviewed face-to-face.

5.3.2 Initial negotiations

Women referred through the snowball method were initially asked by their referrer whether they would like to take part in the study and then their contact telephone number was provided to me by the referrer, or they contacted me having been given my contact details by the referrer. Having had a referral, I contacted all prospective participants by telephone initially and at that time they were all verbally informed of the purpose of the study and that I was seeking women who had had a diagnosis of a psychiatric illness from either a general practitioner (GP) or a psychiatrist. Those who were going to be interviewed by telephone due to their location in Aotearoa/New Zealand relative to • tautahi/Christchurch were told that they would be sent information and consent forms by mail and that once these were returned to me I would contact them by telephone to organize an interview time suitable to them. Those who were to be interviewed face-to-face were given the opportunity to arrange a time and place suitable to them for the interview and told that I would bring consent and information sheets with me and give them time to thoroughly read and decide upon them at the time of interview. My approach was to let prospective participants know both verbally (when organizing an interview time) and in writing (in the minutes immediately prior to interview) that they could withdraw from the study at any point without providing me with a reason for doing so, no matter how late in the research process.

All of the prospective participants were informed of the kind of data collection techniques being used, namely semi-structured audio-taped interviews with the possibility of being asked to complete a timeline, a career family tree or a system theory style diagram (to assist them in their story-telling if it was providing hard for them to tell their story). Prospective participants were told that their audio-tapes would be destroyed after their

interview was transcribed and that they would have an opportunity to amend their transcript in any way they saw fit. They were asked if this suited them and whether they still wished to be part of the study. Any questions they had were answered honestly and a time for the interview, face-to-face or in person, was arranged. None of the women approached declined an interview.

5.3 Information sheets and consent forms

Participants were asked to read the information sheet (see Appendix A) and sign the consent form (see Appendix B) if the interview was face-to-face. Alternatively, if it was by telephone, they had been sent the consent form and information sheet and these had been returned to me prior to the interview. They had been informed in the information sheet and consent form that the tapes would be destroyed once the interviews had been transcribed and that interim transcripts would also be destroyed once they had been amended and finalised by the participants. I asked the participants prior to the taping of the interview to reconfirm verbally that they were comfortable with an audio-tape recorder during interviews. Participants had also been assured that all personal information linking them to their pseudonym administratively (in terms of my address list and any other notes) would be destroyed when they had approved the final copy of their transcript. I verbally confirmed that the finalised transcripts would be kept for a length of seven years after completion of the present research and that then they would be destroyed also.

5.4 Maintaining contact with participants during the research

After the participant's interviews, the audio-tapes were transcribed, the transcriptions were mailed to the participants and they checked them for accuracy. The transcripts were amended by the participants in whatever way they wanted and then a final transcript was generated and the audio-tapes destroyed. Many women wanted copies of their transcripts in

the weeks following their interviews and were provided with them. One woman withdrew from the study a few weeks after her interview due to some of the elements of her story being very traumatic. She contacted me some months later and put herself back into the study. The part of her story that was traumatic for her was left out of her final transcript.

Several participants kept in touch by email or phone and I met with several of the Christchurch participants in the months following the interviews and discussed the data generated informally with them at their request. Two participants emailed me additional information that they felt might be of interest to me. One was a speech a participant had given and the other was a written narrative piece about a specific aspect of symptomology for a participant. I have also, since collecting data for the present research, found myself to be a fellow client of a couple of the women in the present research at respite care or rehabilitative community services during my writing up phase. One participant did not want to acknowledge in that setting that she had been part of the study and I respected her confidentiality and anonymity. The other participant discussed what I had found in the data and asked how my writing up phase was going. Close to finishing the writing up of the study I met some of the • tautahi/Christchurch women who knew one another and had referred one another into the present research as participants. We agreed to have a group meeting between them and myself once my thesis was finalised to discuss the outcomes of the present research further with them.

5.5 Data collection

5.5.1 Interviews

Data collection took place using a phenomenological, biographical story-gathering interview approach between 22 December 2005 and 27 September 2006. Fifteen women were interviewed. The location of the interview (if it was face-to-face) and also the time and the date on which an interview was undertaken were decided by the participants. The interviews

were all semi-structured although later interviews also included some probing on specific areas, if they were raised, since these areas had been identified in early coding as significant to data analysis. This happened with the interviews of participants 12 through 15.

Preparing for audio-taping the women's stories

I taped my interviews because I wanted to make sure that I 'heard' the women's stories clearly and also so that women could check transcripts and be 'in charge' of their story in a way they could not have done without audio-taping and verbatim transcribing. Prior to switching on the audio-tape recorder, at the beginning of each interview appointment, I confirmed the confidentiality of each participant's personal identifying details and ensured each participant that the interview contents would remain anonymous as per the consent form and information sheet. It was important that prospective participants were assured of their rights to confidentiality and anonymity (Couchman & Dawson, 1995; Glesne & Peshkin, 1993, Lofland & Lofland, 1995; Tolich & Davidson, 1995; Yin, 1994.) However, one participant who has a high media profile, insisted on waiving, in writing, her right to confidentiality and anonymity in the belief that it was impossible for her story to be told and her to remain unidentifiable. She did however choose a pseudonym and many of the identifying features in her story were anonymised.

I asked all of the participants to choose pseudonyms that would be used when writing up the results of the research. I asked the women to choose the name of a flower to represent themselves to ensure their confidentiality. Some of the prospective participants were unhappy with being anonymous and wanted their names to be in the research report as a testament to their experience. I was not able to honour their requests since I was bound by the conditions the Human Ethics Committee had placed upon approval of my research. They agreed to chose a pseudonym and continue on with the study.

Audio-taping the women's stories

Interviews were semi-structured, ranging from an hour to an hour and a half in length. Information on participants' work-lives, social systems, career beliefs, sense of self and experience of mental distress/psychiatric illness was gathered. No set questions were asked to gain this information. Areas covered included:

- a chronology of participants' lives (often using a timeline to aid the process)
- an occupational family tree
- participants' feelings and beliefs about their lives and work

During initial interviews, participant-developed drawings of the systems operating in their lives were used. The idea for this came out of Wendy Patton's work on career systems (Patton & McMahon, 1999.) The purpose of these drawings was to assist the participant in recalling and ordering events and aspects of their lives and careers. However, this was abandoned after the first few interviews since participants did not find the tool useful. Some found it conceptually confusing even, and it produced no useful additional data.

All interviewees were initially asked to tell their 'story' (Roberts, 2002) of their work lives and their experience of psychiatric illness. As Grant and Johnston (2006, p. 111) note "‘tell me a little about yourself’, the classic line in career counselling, is not only a good opener, but, if used appropriately, it is the only way to begin. When clients are left on their own, it is mostly what they can say about themselves subjectively that determines what they become." Devault (1990, p. 99), coming from a feminist perspective, would disagree with this when she says that getting "useful accounts of women's experiences is not simply a matter of encouraging women to talk." However, since my approach was a grounded one, I did not wish to proscribe which kind of narratives was 'useful' and which was not. I was rather more interested in seeing how ingrained discursive styles (Gluck & Patai, 1991) and inherited social beliefs might cause silences and 'truths' in the women's accounts. I was not prepared to shape the accounts (Roberts, 2002) the women gave beyond what was avoidable (for example, the interview process is inherently power-laden and participants can endeavour to

fulfil the expectations they believe an inquirer might have). Additional topics for discussion with participants were noted and added to future interviews as theoretical categories developed.

5.5.2 Method/methodology issues that influenced the task of data collection

My data collection interest was in generating themes from the 'ground up' and also using narrative analysis to examine wider contextual issues and the ways in which the women in the study framed what had happened to them after medical diagnosis with a psychiatric illness. Since there is little research on the impact of psychiatric illness on career identity, a modified grounded approach such as I used was useful as a way of researching something that has very little existing research on it (Morse, 1992.) An inductive, modified grounded approach therefore provided an appropriate framework for collecting the stories women told about their experience of work and careers while having a psychiatric illness. One of the impacts of such an approach is that it requires the researcher, as the main research instrument, to guide but not direct the data collection. What emerges from the interview as data is not generated from preconceived notions of what might be discussed. For example, another study might be specifically looking 'at' and 'for' discrimination issues but the present research's methodology meant that such issues might be generated or they might not be generated based on the way the participants chose to tell their story. Later participants, once some thematic analysis had been done on earlier interviews, were probed on specific issues (for example the role of key workplace colleagues in them staying at or returning to work) that were forming a thematic patterning in the present research, if they brought them up themselves. The grounded methodology meant that when no significant new data had emerged and strong thematic categories had been developed, theoretical saturation could be said to have been reached (Strauss & Corbin, 1998.) This meant that the sample size was determined by the methodology of a grounded approach and could not be dictated by me as the researcher. Therefore, by the eleventh interview, a collection of salient

experiences, thoughts and beliefs had emerged and grown into themes (Charmaz, 2006; Glaser, 1979, 1992) by which the rest of the later interviews were coded. Later interviews were monitored for the possibility of new themes that did not, however, arise.

Other methodological issues that affected the data collection were the main snowballing method of recruitment that meant that I was left at theoretical saturation point with only one woman of Māori descent in my sample. My bicultural sentiments felt humiliated at the thought that I had somehow managed to produce an almost entirely Pākehā/palagi sample. Also my idea of using a timeline to assist people in telling their story came out of the narrative approach to the present study. In fact, this method of generating data proved ineffectual and unproductive since it did not help the two participants who tried it. It was therefore not continued. I also thought that a systems approach to mapping career histories and the way that they intersect with cultural contextual factors and chance events might help participants tell their story if they were struggling, but the two participants who did try this found it confusing and unhelpful and did not understand its relevance. A career family tree was generated by four of the participants who wanted a visual tool to assist them in telling their story in terms of what Māori would call their whakapapa. They wanted to convey a sense of their story beginning before them with others in their family – both in terms of career and psychiatric illness. From a social-constructionist point of view this was helpful because it helped to convey an idea of the traditions in the participants' families in terms of gendered work roles and socio-economic status. The career family tree was the only additional tool, besides the interview itself, that helped participants. It led them to talk about their forebears in a way that produced rich textual data from their transcripts. Despite the use of all these other tools, the semi-structured audio-taped interview was the best tool for data collection. Family trees, systems diagrams and timelines are not reproduced in this thesis because they were assistive tools to generate conversation with the researcher. Such conversation was taped. Also, as tools, they clearly named places, peoples and events that could identify the participants who used them.

Salient features from the women's lives that might identify them to others were removed from their transcripts and place names, family member's names, health professionals' names and business names were anonymised. As has been mentioned, one participant is such a high level public figure that her confidentiality was not possible and she was happy that identifying features were left in her transcription because otherwise her story would not have been usable. However, in her transcript, place names, businesses and people's names, etc, were nevertheless changed to fit the style of other transcripts. Due to the need for anonymity, I struggled with whether to use pseudonyms or not in the final writing up of the participants' quotes in the thesis. I tried both using their pseudonyms and not using their pseudonyms and read the thesis through both times to see how this might affect a reader. There is a risk in leaving pseudonyms in that women would be identifiable should a reader decide to trace all of the quotes from a particular participant, as well as my comments about a particular participant in my own text, and try to put together a composite picture of her. I decided in the end not to include pseudonyms in brackets after a quotation from a participant's transcript and, in my own text, not to use the pseudonyms or make general comments about particular women using their identifying pseudonyms.

5.5.3 Literature

Grounded theory was not intended to be used with *a priori* literature reviews. Therefore, I undertook no deliberate literature review prior to the present research. I did undertake one during the data analysis phase and developed it into the writing up as is traditionally done in a grounded approach. The focus of the literature was influenced by the data, as per a grounded methodological approach. This meant that the literature needed to be in two parts because the women told the story of their psychiatric illness experience as well as their story of how it impacted upon their career development. They told of diagnosis, treatment and the mental health system, and so these aspects of psychiatric illness needed to be explored by the literature. They also told of their experience as women, and sometimes as lesbians, and

how this intersected with their experience of psychiatric illness and work. Therefore career development literature on women and lesbians was included in the literature review. Some of the women's experiences intersected with Māori culture and were specifically about New Aotearoa/Zealand issues such as the anti-discrimination campaign *Like Minds, Like Mine* that has been currently operating for over ten years. So brief overviews of Aotearoa/New Zealand as a place to experience psychiatric illness, as a bicultural country, and as a place to experience career development issues were also included in the literature review. Career development literature on psychiatric illness would have been important no matter what methodological approach had been taken but specific issues such as notions of progress, the neo-liberal economic climate and the place of the Protestant work ethic (Weber, 2002) in Aotearoa/New Zealand were specifically covered in the literature review because the data from the participants generated a need for the literature review to include them.

5.6 Data analysis

5.6.1 Method/methodology issues that influenced the task of interpretation

An inductive, modified grounded biographical approach certainly provided an appropriate framework for exploring the stories women tell about their experience of work and careers while having a psychiatric illness. Symbolic interactionism and a social constructionist lens were used to examine wider contextual issues revealed by the data. Narrative analysis was used to explore the ways in which the women in the study framed what had happened to them after medical diagnosis with a psychiatric illness. These lenses influenced the task of interpretation by making me look for certain features in the terrain of the women's stories. I looked for contextual factors, meaning making based upon interaction with others and wider society, a sense of order and plot that showed organizing principles at work in the narratives. I came to see that there were various 'literacies' or discourses around mental health issues that were shared by some actors and not others in the women's narratives. What became

evident were the various tensions, sometimes competing, that influenced the participants' life-story narratives.

5.6.2 Content analysis

I coded all of the interviews which had been transcribed verbatim (Denzin, 2000; Huberman & Miles, 1994; Lofland & Lofland, 1995; Ryan & Bernard, 2000.) My early interviews had been unstructured and allowed the field of enquiry to open out (Glaser & Strauss, 1967; Glaser 1978, 1992.) I used open coding firstly to develop categories out of the data (Denzin, 2000; Tolich & Davidson, 1995.) In grounded theory, particularly espoused by Strauss (Strauss & Corbin, 1990), coding line by line generates codes and themes. While the method used in the present research involved finding the theory grounded in the data, as in grounded theory, my actual coding was undertaken in a way that can be called thematic analysis (Ezzy, 2002.) I did not dislocate the participants' transcripts line by line (Kearney, Murphy & Rosenbaum, 1994.) Rather I took segments (a sentence or a paragraph) of what was said and coded it to generate themes. This allowed me to maintain a macro level awareness of the sweep of the women's stories in terms of applying narrative analysis to their biographies. The research is still inductive and grounded in nature but it is not pure grounded theory. At around the eleventh interview, I found that a collection of salient experiences, thoughts and beliefs emerged and developed into themes (Charmaz, 2006; Glaser, 1979, 1992) by which the rest of the later interviews were coded. As categories emerged and key themes developed, later interviews were still unstructured but I probed at times when participants' stories covered the areas significant to the emerging themes (Ezzy, 2002; Wimpenny & Gass, 2000.) I monitored later interviews for the possibility of new themes - that did not arise - and I undertook interviewing until saturation of data occurred and no new coding was generated (Streubert & Carpenter, 1995.) Theoretical saturation (when there is no more to be added to the theory generated by the research) occurred by the fifteenth interview (Glaser & Strauss, 1967; Richardson 1990; Roberts, 2002.)

The outcome of data analysis was the thematic generation of categories (Ezzy, 2002.) Essentially, I “disassembl[ed] and reassembl[ed]” (Ezzy, 2002, p. 94) the data, systematically and rigorously. I broke the transcripts up into lines or short paragraphs that I analysed and coded and rearranged under specific themes to produce new knowledge on the subject. I examined the data for similarities and differences within the themes generated (Ezzy, 2002.) I then developed a discussion of those themes through the use of the theoretical lenses chosen for the study. Establishing relationships between categories and then relating the categories back to several key themes produced the final theory in the research process (Denzin, 2000; Strauss & Corbin 1990.)

5.6.3 Themes generated

Data analysis identified three major categories and their sub-categories. These three categories provide the framework for presenting the research findings.

The first major category was ‘Getting unwell and getting help’ and the five sub-categories under this were: situating the women’s stories - ‘madness’ and ‘mental illness’ across the generations; ‘madness’ or ‘mental illness’ – psychiatric imbalance before and after diagnosis; diagnosis as a social ritual of identity change; a modern ‘take’ on medication and treatment after diagnosis; and identity loss - discrimination and stigma.

The second major category was ‘Getting better’ and the five sub-categories under this were: disclosure; recovery and accommodating change; the impact of family, partners and friends; the impact of employers and work colleagues; and the impact of mental health services and service users.

The third major category was ‘Getting back to work’ and the three sub-categories under this were: the impact of the internalised ‘Protestant work ethic’ (Weber, 2002); the functions of work for women experiencing psychiatric illness; and integrating psychiatric

illness into worklife – accommodations and limitations (returning, coping, making adjustments and daydreams.)

5.6.4 Data analysis and strategies regarding researcher positionality

The impact of my positionality on the research approach is worthy of consideration. It is inevitable that researcher ‘bias’ will enter into a researcher project. I spent many of my early years working in the mental health sector with views that might be best summed up by this excerpt from one of Anna Livia’s novels:

Polly was too wary of the State system to allow Sadie into its hands without a fight: its values that smelt of methylated spirits, its welfare kindness which asked that you participate in your own reformation; its codes which protected the powerful from their power. ECT, to be used only in extreme cases, like when patients are too dopey or relatives too desperate to refuse. Rows of metal beds and shell-shocked inmates in night clothes to lend them the status of illness. (1985, p.90)

Despite my opinions having been tempered over time by experience of advances in psychiatric treatment – especially following deinstitutionalisation and the era directly after the *Mason Report* (see Part B - Literature Review) – I still came to this study expecting to hear largely about discrimination and other negative experiences. I was, however, able to learn through the research process that such expectations did not prove to be borne out by the data I collected and analysed. This kind of ‘bias’ or opinion is only a problem when the researcher neither acknowledges it to themselves nor is aware of it critically during their research project. It is also a problem if the researcher does not state their position clearly so that readers of the research are aware of their positionality with regard to the topic (Griffiths, 1998.)

Reflexivity is useful as a tool to deal with issues of researcher positionality that might arise during data analysis (Charmaz, 2006.) I have explained my position with regard to my interest in and experience of the research topic prior to undertaking the research, the method of selecting of participants and the outcomes produced by this, how I dealt with the context of interviewing and how my values might have affected data collection and analysis.

Therefore, readers of the present research can clearly understand to what degree and in what way my interests, assumptions and theoretical and socio-political positioning influenced my particular interpretation of the data I collected (Charmaz, 2006.) Obviously, by using a grounded and content-analysis approach, the themes generated will have been influenced by my subjective experiences as a researcher. However, the methodological approach used will mean that such thematic coding still will have highlighted the meaning-making of the participants more than that of the researcher.

I must acknowledge that I was surprised by the acceptance and lack of grievance directed at current psychiatric personnel and GPs by the women I spoke to. It was fortunate that I did snowball sampling and took a grounded approach to data collection. This allowed me to keep my distance methodologically and allow the women to speak their own 'truths.' It was at first unnerving and then refreshing to be made to look at the data not through a lens informed by discrimination and stigma issues and an anti-psychiatry stance, but more through a growing awareness that the Milletesque horror story was missing from the data in every aspect of it, except the older women's accounts of earlier experiences of psychiatric treatment.⁴⁸ There were no horror stories. The former journalist in me wanted a decent tale to tell, the former mental health service user/'consumer' in me wanted acknowledgement about the shocking experiences women like me had had with mental health services in the past. I had to learn to resist my previous psychiatric knowledge and my previous journalistic 'take' on life, and embrace the data influences that were presenting themselves. I have come to see how it is that women in Aotearoa/New Zealand in the early years of the new millennium had quite different stories to tell from those that have gone before, for example Kate Millet. The mental health field is constantly changing and a sense of progress towards more emancipation and less alienation is being experienced by many users of mental health services. What I learned helped me personally to trust the process I found myself going

⁴⁸ From women in contact with mental health services and GPs at an earlier time, the stories matched my own and those of my peers in the 1980s and early 1990s.

through in my *annus horribilis* of 2008.⁴⁹ It also made me a much better researcher and for that I am grateful. This is not to say that my experience has been without negatives and that the participants in the present research have not experienced issues and problems that they have had to struggle to overcome.

5.7 Limitations

Mays and Pope (1995) note that there is a range of strategies that is available to qualitative researchers to guard against biases. They feel that this is important because qualitative research in the medical field is often criticized for being biased and uncritical (Barbour, 2001.) It is criticized in this way when it is perceived as being “merely an assembly of anecdote and personal impressions, strongly subject to researcher bias” (Mays & Pope, 1995, p. 109) and also because it is often argued that “qualitative research lacks reproducibility” (Mays & Pope, 1995, p. 109.) While it could be argued that reliability and validity are quantitative constructs that have no place in qualitative studies, nevertheless rigour through a systematic research process should be a goal in qualitative research (Seale & Silverman, 1997.) A qualitative study can be robust and data analysis techniques based on conversation analysis that are systematic due to the use of clearly defined theoretical lenses can also ensure that the project has rigour (Seale & Silverman, 1997.)

It is crucial that a qualitative researcher is very clear about choosing methodologies and methods that legitimate the study by ensuring that it has a robust design (Mays & Pope, 1995; Seale & Silverman, 1997), and I feel that this has been achieved in the present research. Chiovitti and Piran identify grounded theory as a useful tool to ensure rigour based on “credibility, auditability and fittingness” (2003, p. 427.) A qualitative research project using a grounded approach, when undertaken with rigour, will have allowed the participants to guide the inquiry process, used the participants' own words in the theory, ensured that the

⁴⁹ In 2008, I experienced profound mental unwellness and attempted suicide twice and came to need wrap-around mental health services such as the Psychiatric Emergency Service, respite care accommodation, and community support services, as well as the temporary suspension of my PhD candidature.

theory clearly comes out of the participants' meaning-making, been clear about the participant recruitment process, made clear the scope of the research in terms of what it could and could not achieve, and related the literature to each thematic category that emerged (Chiovitti & Piran, 2003.) The present research undertakes to do all of these things.

Statistical generalisability is not possible in qualitative research (Barbour, 2001) but generalisations can be made when, during thematic analysis, theoretical saturation indicates that there are no more thematic categories or sub-codes to be identified in the data that is being collected. Since theoretical saturation is not well understood as a method of achieving generalisable findings, it may well not be as influential in evidence-based policy-making as more statistical methods. This is more a limitation in the understanding of the policy-makers than in the method of using theoretical saturation in research itself. Furthermore, in a study such as the present research, using a snowballing approach can help to access participants⁵⁰ who might be hard to access by quantitative studies (Priscilla, Robinson & Tolley, 2004) and this helps to guard against the "bias inherent in pre-existing groups (such as clinic populations)" (Barbour, 2001, p. 1116.)

With qualitative research there is "the infinite variety of angles of approach" (Seale & Silverman, 1997, p. 338) and other researchers might have approached my topic of study quite differently, using questionnaires and focus groups. I might also have used such approaches to provide triangulation, but I agree with Barbour (2001) that triangulation in qualitative research ought not to produce similar findings but perhaps should produce complementary findings which help to add grist the mill of analysis. Qualitative research understands that there are multiple readings and seeks to crystalise (Barbour, 2001) findings rather than provide internal validity through triangulation. For this reason, though popular as proof of rigour, I did not feel that triangulation was necessary. Despite using tools such as a timeline, career family tree and systems diagram to aid participants, I did not see them as

⁵⁰ Of course in my case snowballing led to only one Māori or no Pasifika participants entering the study and this could have been avoided if a different sampling method was used. It may be that a future study will be able to use the present research as a platform for research to crystalise the issues as they exist for Māori and Pasifika women in relation to the world of work and the experience of mental illness.

triangulatory methods. I would argue that, on its own, an interviewing approach with individuals is a useful method for a study in which very little previous research has been done on the topic. Conversation analysis, coupled with such theoretical lenses as narrative and symbolic interactionist approaches to decode meaning from the data, keeps the data from being “mere mysticism [produced by] ... sleight of hand” (Barbour, 2001, p. 1116.) Now that emergent themes have been identified in the field by the present research, I can certainly see how a wider study using a questionnaire might be useful in the future to develop further the theory produced by the present research.

PART D – THE WOMEN’S STORIES

PART D

Introduction

The women's stories⁵¹ are presented in three chapters in a chronologically linear fashion. Chronological themes help to organise the narratives while they do not tell the complete narratives. Certainly, the narrative style all of the participants employed to tell their personal stories had strong elements of the Aristotlean narrative technique and none of the participants began with the present day and worked backwards in their accounts. They followed the dominant construction of time and a sense of 'journey' through a process that dominates most personal accounts in the 21st century. They all began their narratives in the past. The presentation of the women's stories here cannot convey all elements of the women's stories but only a distillation of them, through data analysis, into common themes or interesting counters to those themes that emerged from the data. This section follows a chronological organising schema in the following three chapters, because it allows for the main points from the data to be highlighted around key processes in becoming 'mentally ill.' Diagnosis is identified through data analysis as a transformative event, either for the worse if the participant sees the diagnosis as unhelpful or erroneous or as a launchpad for a gradual return from 'madness' back towards greater social acceptance and support. The participants clearly struggle against losses, and to achieve gains socially, as the process moves beyond the professional diagnosticians' and therapists' domains and out from the mental health sector into the world of family, workplace and wider society. Of course, this process will always involve overlapping and conflictual elements and even regression back to social isolation for people experiencing mental distress and dealing with a psychiatric system plus

⁵¹ Direct quotations from the women, even brief ones, are italicised, indented and separated from the text around them in their own paragraphs. It is usual to lift quotes of fewer than 40 words into the text around them. This is not done in the next three chapters so that the women's words clearly stand out from quotations from publications and indeed from the commentary going on around them.

social systems in which both of these operate. Life is messier than any account can convey in an Aristotlean sense. Life is not ordered and tidied and 'made sense of,' simplified to key messages or land-mined with textual silences where uncomfortable or 'unacceptable' parts of the event are left out, either due to the nature of interaction with the enquirer/interlocutor, a lack of effective meaning-making on the part of the speaker or the presence of conditions of power and alienation that deem topics unapproachable. Life does not contain these things. Only discourses describing life events and the texts created by human beings as social beings can contain these. While some sense of silences or messiness in the linear accounts of the participants is conveyed in the following chapters, nevertheless the themes support a view of a social 'journey' – however ontologically correct or not this is – for the participants through a process of transition and transformation. This transition and transformation is presented by the women largely as a narrative of success, of healing and of richer social interaction with others. It is not without moments of real despair and loneliness. The women's identities are clearly challenged and altered by their being processed through a professional system and their negotiation with family, wider society and workplaces after this. This is a study about psychiatric illness's impact upon women's careers in the widest sense, as well as vocationally, and, because of this, the story presented in these chapters begins long before a return to the workplace. It begins with negotiation with psychiatric illness itself, as a social construct and the processes that create it as a signifier in the women's lives, and then the process they go through – constrained by historical and cultural factors – based upon their acceptance of psychiatric illness as a part of their identity.

In the first chapter (Chapter Six: Getting Unwell and Getting a Diagnosis – Inside the Psychiatric 'Machine') the role of diagnosis is outlined as a fulcrum for the transformation of the women's experiences from amorphous 'madness' to categorised 'mental illness' affected by subsequent treatment approaches inside the psychiatric system. The next chapter (Chapter Seven: Getting Well - Beyond the Psychiatric 'Machine') looks at the experiences

of the women beyond the world of the mental health sector and analyses how they negotiated disclosure, negative social consequences, relationships, and recovery (which reflects for the most part reduction of, and resilience towards, symptoms, rather than full remission of symptoms). The final chapter (Chapter Eight – Getting Back to Work - The Role of Employment and Workplaces in the Women's Narratives of Psychiatric Illness) looks at the role of employment and workplaces in the women's narratives and provides a point of intersection between vocational career issues and psychiatric life-career issues.

CHAPTER SIX

Getting Unwell and Getting a Diagnosis

– Inside the Psychiatric ‘Machine’

Is the system going to flatten you out and deny you your humanity, or are you going to be able to make use of the system to the attainment of human purposes? (Joseph Campbell 1991 p. 144)

6.1 Introduction

This chapter examines labelling and identity issues and begins with the history of family members of participants. Many participants began their narratives before their own birth and related accounts of relatives’ mental distress several generations back. The data about family members are related here first as a form of whakapapa for the participants. This is appropriate in a study based in Aotearoa/New Zealand, a country that has been influenced by biculturalism and by a strong Indigenous culture that puts importance on ancestry and the belief that one can only understand the present and see one’s way into the future if one gives proper honour and attention to the past. The chapter then goes on to look at the difference in the participants’ minds between ‘madness’ and ‘mental illness’⁵². ‘Mental illness’, for the participants, is seen clearly as an ascribed condition based largely on the expertise of professionals and reliant upon the diagnosis of psychiatric disorders based on *Diagnostic and Statistical Manual* classifications. ‘Madness’ on the other hand is, for the participants, an amorphous state of dislocation from normalcy and covers a multitude of aberrant behaviours and mental distress.

The chapter then looks at medication and treatment and finds that participants have largely (though by no means entirely) positive experiences of more modern medications and treatments, such as cognitive behavioural therapy.

⁵² I will use terms such as ‘mental distress’ or ‘psychiatric issues’ when describing psychiatric illness, so that my terminology can be identified separately from the participants’ understandings of the differences between ‘mental illness’ and ‘madness.’

6.2 Situating the women's stories – 'madness' and 'mental illness' across the generations

All but two of the participants related stories of their family members experiencing mental distress. One of the two participants who did not was the mother of another participant. So in fact she did have experience of mental distress in her family but she did not mention it. The other appeared to come from a family with no previous experience of mental distress though this was not interrogated. From a narratorial perspective, therefore, there is only this one participant⁵³ who did not include family data into their story. Most women's narratives do speak of a wider family, both in terms of discussing experience of mental distress and in terms of other influences.

What is interesting is that the participants were not asked explicitly about their family history of experience of mental distress, but they volunteered it. This discursive action on their part clearly supports their view, to be discussed later in this chapter, that mental distress is biologically-based and can genetically endowed in many cases. These comments convey this clearly:

Probably, because my grandmother had been mad, I would say this was Grandma coming out in me is probably how I – how I, er, rationalised it, if anything – tried to make sense of it.

I left school after seventh form and went to teachers' college in X [names a South Island city] and I flew through my first year not realising how depressive I was, how unwell I was (pause) which in our house should have been picked up because mental illness is everywhere. My mother, her mother, just all over the show.

Not all of the women had the same disorder classifications as their family members. In fact, most did not. So the genetic endowment must be seen as a general predisposition to mental distress that required professional help in most cases. Some women, though, clearly saw that the generation above had genetically given them their particular psychiatric category, as the following comment pithily conveys:

Mum's got agoraphobia. I've got agoraphobia.

⁵³ The one participant who did not mention her family, did, however, have a female civil union partner with experience of mental distress. So, if family is extended to include partners, then in fact all of the participants had 'loved ones' who experienced mental distress. Almost half of the participants in the present research had a partner – again a non-biological 'family' member – with experience of mental distress (in the case of this study's participants 'partner' refers to either a lesbian *de facto* partner, a lesbian civil union partner, a *de facto* male partner or a husband.)

The fact that illness categories were not conveyed down the generations for the most part may also be due to the social construction of mental distress and shifts in trends to identify or classify certain behaviours, thoughts and feelings as a particular diagnostic classification. As has been seen in the literature, diagnosis has been changing over the centuries and even faster over the later decades of the twentieth century, influenced by medical advances, social movements, pharmaceutical companies and insurance systems.

As has been noted, most participants in the study gave accounts of their relatives having been diagnosed formally with a psychiatric disorder. However, it is important to be clear that not all diagnoses of a psychiatric disorder in a family member came with a distinct illness category such as depression or 'Scruples'.⁵⁴ Some relatives were not given a definite diagnostic classification but nevertheless experienced generalized psychiatric inpatient treatment. These relatives tended to be in the great-grandparents' or grandparents' generation. One participant talked about a great-grandmother who had been in a psychiatric institution for most of her life, which was a common form of treatment for a psychiatric disorder at that time:

My birth grandfather on my mother's side, his mother was actually in X [names North Island inpatient psychiatric unit] for her entire adult life ... and they thought she was as mad as a hatter ... So she got hospitalised at X [names North Island inpatient psychiatric unit] for over 40 years and was always (inaudible) but they wouldn't let her out.

There were also accounts of grandparents experiencing mental distress and the ways in which this affected their vocational functioning. All but one participant with a grandparent with mental distress related how their grandparent had a job and maintained it despite mental distress. For example, one participant's grandfather was a schoolteacher who battled depression:

My father's father, who was a school teacher - he had depression. He struggled with depression.

⁵⁴ St. Francis de Sales (1567-1622), Bishop of Geneva and Catholic saint, was one of the first people to describe 'Scruples,' an affliction with which one of his friends suffered. It is understood today as a religiously-focused type of obsessive compulsive disorder that leads the sufferer away from orthodox obedience to God, through fear of the Devil, towards 'magical thinking' and non-sanctioned ritualistic behaviour. It is not a diagnosis found in the *Diagnostic and Statistical Manual* of the American Psychiatric Association.

The exception to this is the grandmother of a participant who had a private income but lost it all due to what the participant felt had been untreated bipolar disorder:

She was very wealthy, I believe, but due to her illness she lost it all and ended up being a pensioner ... She was as mad as a cut snake but I really liked her ... She was hospitalised, um, quite a few times.

Some grandparents, despite maintaining careers such as teaching and farming, experienced periods of time in a psychiatric unit as the comments below show:

My maternal granddad, unipolar depression. Late onset ... He spent some time in X [names a North Island inpatient psychiatric unit].

My grandfather, Dad's father, actually died in X [names South Island inpatient psychiatric unit.] He spent his last years there.

For others it was their parents' generation that experienced mental distress of varying severity as the following accounts show:

My parents ... not only did they have phobias but they were both completely nutty actually and my father drank himself to death.

My [father] was in Vietnam and became a drug user there and also he was quite mentally damaged with Vietnam ... he is ... a paranoid schizophrenic.

Mum, I know, suffered a kind of a breakdown at some stage when I was probably in my early teens which was pretty hard 'cause that was never kind of talked about and she just kind of cried a lot and went to bed for a few days and the doctor came and saw her and - but I think that was pretty much a breakdown.

*My mother, um, had big mental health issues in the late fifties when she was married with two very young children and hospitalised and went through the whole - the Janet Frame *An Angel at my Table* thing of - she had electric shock treatment.*

What is interesting from these accounts is the social knowledge and the symbols used to explain mentally distressed behaviour, from colloquialisms such as 'nutty' and 'breakdown' that have no diagnostic standing, to references to culturally identifiable symbols of certain kinds of mentally distressed behaviour, such as the Aotearoa/New Zealand film *An Angel at My Table*. In the absence of professional language, these participants are trying to give an impression of what their family members experienced by using discursive signposting to link their individual family members to a wider social phenomenon of 'nuttiness' and 'breakdowns'.

One participant's account resonates with a sense in which, in previous generations, farmers had no choice but to work while coping with intermittent psychiatric hospitalisation since they experienced mental distress during a time when the Welfare State was not as open to supporting the psychiatrically unwell through benefits:

My mother went into a psychiatric hospital when I was born and I think she might have come out a few times but basically she stayed there until I was over a year old ... my mother was a dairy farmer's wife and she worked all the time apart from when she was in hospital. She went from the cow shed to hospital and straight out of the hospital into the cow shed, (laughs) you know, cooking and cleaning and milking cows.⁵⁵

For a farmer in the next generation of the same family, support was better in terms of the Welfare State, but mental distress still affected this relative vocationally and financially, as the following comment shows:

Um, my brother has bipolar disorder ... [he] bought his own farm because he was a bit hyper, you know. He actually did very well and then he got really depressed and he sold the farm and, um, he became a horticulturalist. He couldn't handle that and so he is an organic vegetable farmer, um, part-time and he's on a benefit part-time.

It is interesting that terms such as 'nutty,' 'mad as a hatter' and 'mad as a cut snake' which were largely (but not exclusively) used by participants to describe previous generations were missing from descriptions of family members of their own generation who experienced mental distress. This is perhaps because participants look back through a lens of childhood on older family members and therefore sometimes use more informal language. Certainly, when talking about their own generation, the language used by participants does not use terms such as 'mad as a cut snake.' It is more clinical, for example:

My brother, who's slightly younger than me, suffers from schizophrenia. He is 42. He is medically managed well at the moment but he has been in and out of the secure local ward.

Finally, some participants had family members in the generation below them – children, nieces and nephews – who experienced mental distress, as the following accounts indicate:

My nephew got a first attack [of bipolar disorder] at 32.

⁵⁵ It is probable that farmers today still 'soldier on' despite psychiatric illness like this participant's mother. It has been recognized that there is a valid suicide risk among farmers who suffer from depression but lack the support of psychiatric or social services (Gregoire, 2002.)

I've got a - my cousin's son at the moment is, um - they've just asked for support because he had been suicidal, several times - he and his sister - so that's my first cousin's two children are both suffering depression.

In conclusion, it can be seen that participants' experiences mirror wider experiences in society in Aotearoa/New Zealand. One in four or five of the population has experienced mental distress in this country, which reflects a similar position in most Western countries, and there also is widespread belief that mental distress can be genetically endowed (Rack, 1982.) Almost half of participants in the present study had blood relatives in their grandparents' generation who had experience of mental distress. Two thirds of participants had blood relatives in their parents', uncles' and aunts' generation who had experience of psychiatric or addiction issues. For some of these people this was treated with shock treatment,⁵⁶ inpatient care for over 40 years and even a lobotomy. From the participants' data on family members' mental distress, unprompted by the interview process, it can be conjectured that this level of mental distress experience is common in many families in Aotearoa/New Zealand. Discourse around familial mental distress may well have been prevalent in their lives long before their own experience of mental distress, as their own family members have attempted to cope with the psychiatric issues that have confronted them. The shifting socio-cultural influences on treatment of mental distress are clear in the way that participants used language around their family member's experience of mental distress. They convey the sense of a shift in the way people with mental distress were treated, for example, the fact that one family member could be hospitalized for 40 years in the early and mid- twentieth century but another family member would be 'in' and 'out' of inpatient care in the new millennium. Accurate naming of an illness is conveyed in the interviews for the participants' own generation and for the generation below them (ie, children, nieces and nephews) but it is not as evident for the generations above. The participants' narratives about their family members give a sense of gradual historical shift in ways of dealing with the idea of mental distress and with the mentally distressed themselves.

⁵⁶ Shock treatment – or electro-convulsive therapy (ECT) – is viewed negatively by a wide section of the population though it is also increasingly seen as being helpful in depressive illnesses (Jamison, 1996.)

6.3 'Madness' or 'Mental Illness'? Psychiatric imbalance and the fulcrum of diagnosis

Despite participants having a 'literacy' around psychiatric issues (which participants' accounts of their journeys back to wellness and work will show further on) the language of 'madness' or craziness, rather than 'mental illness', is nevertheless usually used by participants to describe historically the early part of their journey through mental distress, as can be seen from this comment:

I didn't see the problem and I just - I felt like everyone thought I was crazy or something.

Review of the transcripts of interviews with the participants in the study showed, from a discourse analysis perspective, that 'madness' is often a state referred to before medical labelling with a 'mental illness' has occurred in the history of the participant, as the following participants' comments show:

At that stage I didn't know that that's what I had and I had this sort of sense of foreboding that there was something deeply wrong with my brain and that I was going to get in really big shit one day ... I had begun feeling like I was about to go mad.

I would drive in the car and think about driving into traffic poles or just putting my foot down and swerving in front of a car, and, um, knowing that that was just madness. That that's really mad to think that, but not thinking that I needed to do anything about that ... I'd done therapy about my relationship with my mother but hadn't made the connection that I was unwell ... there's been that taboo about being mad, whatever that means.

Well, when I went into X [names South Island psychiatric inpatient service] it was when I was 12. I was really terrified about going in. It was like - I just really didn't want to because I hadn't actually realised that there was a problem. Like, I thought, "oh this is so normal, you know - this is my problem." I didn't actually realise it was as serious as it was and I didn't see the problem and I just, I felt like everyone thought I was crazy or something.

It can be seen from this section that the notion of 'madness' (or craziness) is seen as different from 'mental illness.' 'Madness' is seen as an out of control, difficult to conceptualise, frightening state to be in. 'Madness' is used clearly to define what had not yet been psychiatric diagnosed. 'Madness' can be understood from one perspective as existing in the self-talk of the person with the illness. It is a descriptive code for feelings and experiences they cannot understand in any other way. It seems to be a term applied retrospectively when the person who says they have experienced it feels they had little

sophisticated analysis at the time of what they were going through. All they knew was that something was wrong at a certain time in their history with their feelings and behaviour. The individual's cultural knowledge of their aberrant perceptions and behaviour indicates that these impulses - 'out of step' as they are with societal norms - have historically been referred to as 'mad'. Therefore they ascribe the title of 'madness' to their experience.

Certainly the medical profession no longer officially uses the term 'mad'. The old 'mad-doctors' and alienists (those who provided treatment to those alienated from society by their mental distress) have become neurologists, psychologists and psychiatrists and still today a few are psychoanalysts. To them, 'madness' officially no longer exists though the wider society in which they live and work still calls some of its citizenry 'mad' as do some of those 'mad' people themselves. In the New Zealand document *Our Lives in 2014 – A recovery vision from people with experience of mental illness*, the authors note that:

Mental illness did not have universal support from the tangata motuhake [people with experience of mental distress] involved in this document because it reinforces the dominance of biological approaches. Some wanted to reclaim the word 'madness' but a few found this word either too colloquial or offensive. (Mental Health Commission, 2004, p. 9)

Like Kate Millet, it would seem that an overtly political consciousness towards psychiatric issues in the long-time psychiatric service-user consultants who contributed to the document, led some of them to contest the term 'madness' and dispute the term 'mental illness.' Despite this, understood socially, 'madness' is usually viewed as an amorphous, fearful thing for society where, at its worst, there is cultural fear of dehumanised people terrorising and threatening the sane citizenry. Certainly, 'madness' is a single unit of qualification unlike 'mental illness' with its constant breaking down of units of aberrant behaviour and motivation into still finer definitions of psychiatric, neurological and psychological disturbance.

The transition from talking about 'madness' to talking about 'mental illness' in the women's narratives brings with it a psychological sense of order and security. In their narratives, discrete 'mental illnesses' become ascribed to their previously amorphous 'mad'

states. This is done through interaction with a medical ‘expert’ such as a general practitioner (GP) or a psychiatrist and through undergoing the process of diagnosis. The transition from an amorphous state to a diagnosed state is captured in these comments about going to see a GP:

I went to the doctor and said “I think I need some time off,” and she said “I think you’re chronically depressed”.

I made my appointment with my GP and had a locum instead and thought, being my usual self, that I wouldn’t actually tell her too much but as soon as I got sitting in the chair I just burst into tears and it all sort of came flooding out and she said straight away “I think you’ve actually got quite serious depression and there’s no way you’ll be back to work”.

Most participants had a positive first experience of having their ‘madness’ diagnosed as a discrete ‘mental illness’ as this comment shows:

The other thing too that the diagnosis has done for me is it explains so much.

This was not the case for all participants as this participant’s comment shows:

I had terrible panic attacks and was up in the hospital with this stupid doctor who decided that I’d taken on the symptoms of my father and thought I was dying because he was.

Another participant felt aggrieved that she had had to wait years for what she saw as the correct diagnosis. Her discourse intimates that getting the diagnosis she received in her 40s was important to her in a positive way.

So I would have been about 40 or 41, something like that, when I actually got diagnosed as being bipolar and started on mood stabilizers.

For a ‘mental illness’ to be formally present medically it requires a diagnosis based on the *Diagnostic and Statistical Manual* of the American Psychiatric Association. However, self-diagnosis preceded formal diagnosis for some participants. For one participant a university course provided the tools:

I found I had agoraphobia and it was during a paper called ‘Abnormal Psychology’. ... It had a name and there was treatment for it.

For another, the media provided the tools:

Prior to that physical collapse, about a week prior to it I’d had a lot of palpitations in bed and feeling very flustered and didn’t actually put it down to stress. I actually put it down to cardiac issues and then the day before it all happened there was a feature article in X [names a South Island newspaper] that talked about stress overload and

that was my first time that I thought maybe this is actually mental and emotional rather than physical.

Participants show a tension between accepting and rejecting aspects of being diagnosed. In the case of a diagnosis of depression, two participants, through the use of the words 'just' and 'only,' soften the seriousness of their 'mental illness' category.

I went to my doctor and I said I wasn't coping and I was flat and very little excited me, and, you know, just those classic things of depression.

When I was 18 and 23 it was only depression.

Depression is far more widely accepted in society today and is a relatively stable diagnostic category that has not been influenced by major interpretive change in the *Diagnostic and Statistical Manual*, as the word 'classic' used above seems to convey. Depression and anxiety disorders such as obsessive compulsive disorder (OCD), unlike other psychiatric categories, are no longer as vilified through prejudice as they were in the past. This is due to better medication, more public knowledge about them and a societal understanding that they usually require GP rather than inpatient care. This may be a reason for the participants' 'softening' discourse techniques.

One participant questioned her diagnosis because she was afraid of its consequences in terms of being associated with psychiatric categories that are not as acceptable in society as depression and anxiety. This may be because, aside from a general social fear of amorphous 'madness' states, some psychiatric categories themselves do bring with them their own cultural fear, for example schizophrenia which has been the subject of many inaccurate Hollywood movies such as *Psycho*. The participant clearly did not want to be associated with carriers of such psychiatric categories:

I thought, you know, 'they - that's not me - actually, I'm supposed to be with Maternal Mental Health.' Because, I think that's got a softer kind of feel to it, which is terrible to think that, but, internally, that's exactly what I thought. I thought, 'shit, no - there's no way, yeah, and, oh, my God, am I heading towards that?' That was a frightening thing. It was, like, 'far out, man, I don't - this is me now but I don't want to be like that later.' The term mental illness, if I didn't work in the profession that I did - I'd probably go 'no, no, no, no, no, no, that's not me.'

The participant quoted above is so stricken with panic about being part of a psychiatric grouping outside maternal psychiatric services that she indicates she would have rejected

the concept of 'mental illness' as a signifier for her own situation if was not that she already worked in the profession. Conversely, another participant found that stories of others who had 'mental illness' and survived it helped her synthesise it into her own identity:

It kind of helped because ... there's other people who've had this before. It's not just some random thing that I have. And it's sort of like, well, if other people can deal with it, then I should be able to as well. So it kind of makes me feel better about it.

Other participants spoke about having a 'mental illness' seeming to be more acceptable to some degree in the present day than it was in the past, as the following comment shows:

But I guess it's like people talk more about mental illness and mental wellness and unwellness now than we ever have before as a society.

Two participants in the study who talked about psychiatric diagnosis of the past (one had a mother who was a adult working wife during the 1950s and 1960s and the other was an adult woman herself at that time) use the signifiers 'suburban housewife' or 'housewife neurosis' in a derogatory way in their descriptions of their own or their mother's mental distress, as can be seen from these comments:

It was like she was a suburban housewife even though she worked on a farm.

Stupid old bastard [doctor at hospital] told me that it was just housewife neurosis and that if I held my hands over my eyes, like that, closed my eyes and held my hands over them it would calm me down.

This is not to say that the participants are deliberately being disparaging about housewives. Rather, the expressions they use come from an era when misogyny could be found in the views about women who did not deal well with the socially proscribed subservient role as wife, mother and home-maker in the 1950s and early 1960s. Anxiety and depression in women at this time was not accepted. The participants are speaking of a time when women were largely classified with neurotic illnesses, rather than major psychotic illnesses, and their unhappiness as a disempowered gender under patriarchy in a socially difficult post-War era was routinely medically treated with valium in what became known in some circles as 'the valium era' (see Literature – 2.2.6 The twentieth century: labelling as a sociological act).

One central finding in the present research is that the biologically-based view of 'mental illness' is accepted by all of the participants in the study. Despite the allusion to

'housewife neurosis' above, 'mental illness' is seen by all of the participants as at its core being intrinsically of the 'self' rather than extrinsically proscribed by others due to prevailing cultural ideologies. This comes across in the following comments:

I have a mental illness. There's nothing I can do to get away from it, you know.

Mental illness ... even if I tried to resist or reject it - it would still be part of me ... It's all part of the package that is me and part of that package is bipolar.

6.4 Diagnosis – the influence of professionals

While there seems to be more of an acceptance of present day psychiatry in participants' narratives, the following participants' recollections describe diagnoses that were incorrect or unhelpful:

In the middle of my first year [at college] I ended up basically quite suicidal in hospital for a fortnight where I was diagnosed with a personality disorder because they didn't know. Nobody knew. Neither the GPs nor the psychiatrists acknowledged that you could become so debilitated with phobias, that it would hound you into suicidal depression and that, you know.

I'd get home from school and I would just scoff and scoff and scoff secretly and ballooned appropriately (laughs) but that was all stress. I felt stress. I was consciously stressed and Mum felt I was too - and the doctor, he felt, he put it down to - I don't know what he put it down to but nothing happened.

They diagnosed me with bipolar for years and I think they just wanted to give me a name actually, but I'm definitely diagnosed now with post traumatic stress disorder ... that annoyed me 'cause I never had a high in my life. They gave me education for bipolar and I didn't even have it. It was a waste of time.

Reactions to misdiagnosis appeared to be compliance or frustration. Examples of the former – compliance – include:

I did go and see a doctor about it and the doctor decided that I was depressed and gave me anti-depressants and I thought - I was still convinced I was anxious, not depressed although I know that those two things are quite similar, apparently.

Four years ago I had suggested to my doctor that I thought I might be bipolar. He's not an over-diagnoser which is great – "mmmm, yes, could be cyclothymia".

An example of the latter – frustration – comes from a participant who works in the mental health sector, was diagnosed recently and was frustrated by not being diagnosed medically as she would have expected:

I mean, they - the specialists, whatever - they put it under the umbrella of PND [post natal depression.] I don't think it was depression, post-natal depression. It had huge anxiety symptoms. There's no such thing as post-natal anxiety or a term that they use, but I that's what I think it was ... I don't know, that whole thing about diagnosing people, it was a shit experience (laughs.)

The influence of professionals can also be seen in the following recollection of being forced to try medication despite the participant not believing that she was depressed. The participant felt that she had a physical disorder due to the overwhelming physical symptoms she was experiencing such as lethargy, but her doctor thought differently and convinced her to try anti-depressants:

I went back again to see yet another doctor, still complaining of tiredness and anxiety and she was a doctor that I, by that time, knew somewhat and knew that she was very good and I told her that I kept getting this diagnosis of depression and I didn't agree with it and she said "well I can see why they've diagnosed you because you do have, the sort of things you're saying are depression but they're kind of the same thing. Anxiety and depression can be very similar and hard to differentiate. I can't make you take anti-depressants but you might find that they're very useful and if you don't, stop taking them but if you do, give it a go" ... there was something about her that I found easier to trust and I liked that she wasn't just putting a label on me. She was kind of treating me more like I was a human being that had a brain, that I could think for myself and so I did give them a go and they actually were helpful, very helpful. I stopped feeling so anxious and I was more able to function.

The participant above trusted the professional, in this case, less because of her perceived medical expertise and more because of a more personable approach. Also, she trusted the GP because the GP did not treat her as only a broken vessel but also as someone intelligent and capable. Professionals are often uncritically viewed as having "special knowledge and altruis[ti]c" intentions (Pilgrim & Rogers, 1999, p. 101.) Some participants in the present research indicated that they do not always agree with this common assumption when it is related to psychiatric diagnosis in the past, as has been evidenced in the comments in this section. Most, however, did perceive medical professionals as having such special knowledge and altruistic intentions, particularly those who had been recently diagnosed.

Kate Millet in *The Loony-Bin Trip* says "I'm not your property to have jailed or not ... So don't cooperate with the machine" (1990, p. 295.) She also says, "I could not pit my truth against so many, against the power of science" (1990, p. 309.) Nowhere in the stories of the

women in the present research was there such violent distrust of the present-day medical profession as that articulated by Millet.

Nisbet (1970, p. 63) talks of five types of social interaction which are played out in society – “exchange, cooperation, conformity, coercion, and conflict.” Seen through the lens of this paradigm, the participants in this study can be seen to be experiencing these types of social interaction with their medical professionals. Most engaged in exchange and co-operated with medical professionals even when they were doubtful that the medical professionals were correct. There was little reported coercion or conflict except in the stories of women who had experienced psychiatric and GP services in the less recent past. All of the women conformed in that they all accepted the diagnostic process and the symbolic transition from ‘madness’ to ‘mental illness’ as a necessary act.

The next section continues this section’s examination of diagnosis beyond the broader transition from ‘mad’ to ‘mentally ill’, through interaction with professionals, to look at the women’s more conflictual responses to narrower classifications of particular disorders.

6.5 Diagnoses and labels – acceptability of, and resistance to, certain categories

Some participants had positive feelings about getting a ‘name’ for their mental distress as the following comments show:

It’s good to put a name to it. Not many people know what PTSD is. So, I don’t tell a lot of people ... it’s good to have a name.

I had a name and there was treatment for it. I was disgusted. I was so angry that I’d had these struggles for years and years and years and been told it was a lot of rubbish.

Others, however, disliked the labelling aspect of diagnoses. One participant, while finding a generic diagnosis of ‘mental illness’ helpful and receiving treatment, was not happy to receive a specific categorical label since she disliked breaking ‘mental illness’ down into classifications due to a resistance to labeling:

I hate labels ... Why have them? For some people they’re great ‘cause, you know, they go ‘phew, at least I know why I’m experiencing these sorts of things,’ but, for me

- (pauses.) *It's too complex and ridiculous to split them up even more You know, it's confusing.*

Another participant was frustrated by the labelling process and misdiagnosis:

Well, the only thing I don't like about diagnosis is labelling - is that often they get it wrong and, if they get it wrong, they don't want to admit they're wrong. So people walk around with borderline personality disorder and all this type of crap that they haven't got when it's clear that they've got something else. Like with me, from all the literature I've read, all the people I've spoken to, I definitely have bipolar.

One participant, who has worked in the mental health sector, was aware of a perceptual split in society between the two poles of 'mental illness' – the 'softer' and 'harder' diagnoses:

I mean I'm really aware that people, particularly with bipolar and schizophrenia, find it harder ... they find it more stressful than I have. I mean it does help having phobias as opposed to schizophrenia. Phobias are probably the more acceptable faces of mental illness. Even though people find it hard to understand, when you do explain it they kind of can.

The following participant felt that there was a strong demarcation line between what could be termed the 'softer' end of 'mental illness' – anxiety and depression – and the 'harder' end – bipolar and schizophrenic disorders, as this comment illustrates well:

I think, like, there's mental illness and there's mental illness. To me there's mental illness where someone has a breakdown and suffers from depression for a while and never has another episode in their life. Then there's those of us that have to continually work at being well and staying well, you know.

She uses the term 'those people' to describe people with debilitating psychiatric issues requiring hospitalisation:

To me 'those people' are those that are in a psychiatric unit. They're 'those people.'

The participant quoted below was also happy that her particular diagnosis was one of the ones at the 'softer' end of the scale which is now more accepted in society due to media exposure and celebrities 'coming out' with their own 'mental illness' experience:

Um, I think that, just in light of all the, um, women's mags these days (laughs), so many of the celebrities have had post-natal depression (laughs) it's almost like it's the thing to have so you sort of go 'phew.' No, um, but it is - it's kind of like it's okay. Post-natal depression's one of those things that 'oh yeah, yeah, yeah, it's just post-natal depression' whereas other things (pauses.)

This mention of celebrities is interesting. 'Madness,' certainly, is tolerated in a favoured famous few, largely due to its cultural links with artistic output - but these individuals are the exception to the rule. In the Western world it is 'common knowledge' that Van Gogh was in

some ways 'mad' but that his painting was brilliant and perhaps could not have been so redolent of genius without his 'madness.' He certainly never experienced positive social reinforcement during his own lifetime about his 'madness.' It is only romanticised now that he is a famous painter. The same can be said of Virginia Woolf's writerly acuity (Caughie, 1991.) 'Madness' in creative geniuses may also been seen to be tolerated by society due to its perceived incurability and inseparability from the creative impulse. The same notion of incurability would, however, lead to rejection and stigma to the majority with 'mental illness,' especially in the past. One participant was able to articulate the way that such romanticized notions of 'madness' had been shattered by her own experience of mental distress:

I thought it was a really cool thing. I didn't have a lot of experience with it apart from movies and books and I sort of romanticised Janet Frame and there was a film about Frances Farmer I remember from when I was quite young and I thought that was really cool, like the mad genius. So I had no qualms about mental illness myself. Experiencing it myself, there was nothing romantic about it whatsoever. It was a thoroughly awful experience and one which I really don't want to go through in that depth again.

Unlike some of the other women who have commented above, for one participant the level of social acceptability of her diagnosis was low, and she felt that her diagnosis impacted on her treatment from mental health services:

It doesn't help in one way because when you are borderline personality disorder, until recently, [mental health services] didn't like people with borderline personality disorder because they felt they were - (pauses) they didn't quite - it wasn't in a neat little basket. They couldn't just medicate it and it would be okay ... If I had had something that was more easier to treat or to be managed better - 'cause they say with people with borderline personalities, you put a lot of time into them and they can just change, you know, (pauses) ... you put a lot of effort in and then they don't - they go and overdose on you or whatever - self-harm.

In the late twentieth century and the early twenty-first century 'mental illness,' is medically constructed and culturally appreciated as curable or at least manageable at its supposedly 'softer'/'lighter' end of the scale – anxiety and depression – though still unnecessarily feared at its 'harder'/'heavier' end – bipolar disorder and schizophrenia – despite these illnesses also responding well to pharmacological intervention today and being manageable in the community (as well as not precluding an individual from fulfilling vocational and social experience.) The more tolerable to society the diagnosis, the better it would seem the

individual's ability is to integrate their experience of mental distress and psychiatric labelling into their sense of identity formation.

As anxiety and depression become normalised into the general population, which is signified by their frontline treatment by GPs rather than dedicated psychiatric staff, and the disposition of the media as well as the frequency with which people exchange information with others that they are 'anxious' or 'depressed,' it may be that individuals feel more of a normative inner response towards having these psychiatric issues themselves and will more openly share about them. A more normative response in this way may lead to less feeling of alienation at work and in the family depending on those contexts' specific tolerance for these psychiatric issues. One could perhaps expect anxiety and depression to be better tolerated in a liberal family and in a people-focused occupation (such as social work, caring for the elderly and customer service) as opposed to more conservative families (where the person might be blamed for acting out and having no self control) and more data and process focused occupations (such as driving, data entry, piloting craft and air-traffic control.) Bipolar and schizophrenic disorders tend to be appreciably less accepted in either sphere due perhaps to their greater variation in behaviour away from the social norm and the strong discord between the mainstream agreement of what 'reality' is in society and the individual worldview of the floridly unwell bipolar or schizophrenic person. The more removed from the mainstream's notion of 'reality' and possibility, the more unacceptable and fearful the psychiatric diagnosis becomes.

Participants in the present study, as can be seen from the previous section to this one, seemed to have all accepted that 'mental illness' exists and there was none of Kate Millet's socio-political resistance to being diagnosed with it. However, there still seem to be major issues for people diagnosed with vilified categories of 'mental illness.' Unlike Millet, they want the correct diagnosis and not to belong to a socially vilified group. Millet resisted the basic notion of psychiatric diagnosis itself, seeing it as a political construct. She politically embraced the role of the alienated in order to show that it is the alienating forces and not the alienated group that one should be resisting being a part of.

'Mental illness' was seen as intrinsic truth by the participants in the present research rather than an extrinsically proscribed construct that may be done away with over time. While varieties of diagnosis might be argued over and some discredited, the predominant notion for participants in the present research was that a biologically-based 'mental illness' was what they were all experiencing, not some politically understood notion of alienation due to patriarchy or some other hegemonic power from which they felt dispossessed (which is how Millet viewed her diagnosis and treatment for mental distress.)

Threat to the core social group is seldom tolerated in society even if it is an erroneously perceived threat. Society, to give it its due, attempts to understand these threats if they remain a constant in society over a period of time, as mental distress has, and break them down into tolerable or intolerable units of aberrant behaviour. The codifying of mental distress into psychiatric diagnoses via the *Diagnostic and Statistical Manual's* ever changing guidelines (these changes reflecting cultural shifts in understanding and accepting aberrant social behaviours) presents itself as a social attempt to manage and understand an amorphous, fearful thing by codifying it into units of fluctuating interpretation. The next section looks at the women in the present research's views of the treatment regimens and medications given to them by the medical profession.

6.6 Treatment after Diagnosis

6.6.1 - Medication

Participants had very different experiences of medication from one another. Even the newer types of medication that are promoted as having far more efficacy and far fewer side effects produced varying effects. Two participants were given medication in the 1970s. One had a bad experience of valium:

When my marriage broke up, I had some, I got some valium ... They just had a horrible effect, the pills that he gave me.

The other felt she was lucky not to become addicted to the medication she was prescribed, which was an older benzodiazepine and known to be addictive both physically and

psychologically. She used her own personal agency to avoid addiction and manage her medication use to avoid it:

I didn't get addicted on the medication, but only because I was warned. Had it been up to [my GP] I would have been addicted.

Participants taking newer medications more recently found Prozac to be helpful:

So I had that breakdown and then went to my GP. He put me on Prozac. That was when Prozac was the subsidised one. I'm now on the cheap version. That was really helpful and actually was kind of super helpful; it really made a noticeable difference.

I was treated for depression with Prozac ... It worked and I firmly believe that medications like SSRIs don't work unless you need them. You know, if someone's not depressed they can take Prozac or any of those medications and it will not do a damn thing to them chemically because they don't need it. That's what I believe and I may be wrong with that, but I responded and had a mood lift which would fit with when my body had reached the therapeutic level of Prozac and it was a 20 milligram tablet a day and it took probably about ten days to actually reach a therapeutic dose. I know that I'm quite responsive to any medications and I actually did feel a lift in mood.

Yes, so I found that to be - I found the medication to be good when I had the big breakdown. I upped my Fluox[etine/Prozac] to two. I had only been on one - only for three months this time. I've been on and off them because each time I've felt 'better'. That's the thing with bipolar. I've downloaded heaps of medical studies and one of them seems to suggest that the going on and off of Fluox[etine], of Prozac is not helpful for bipolar. Yeah.

Other participants made the following comments taking other common SSRIs other than Prozac:

I did a lot of research and it was like, well, there are people here saying that going on medication works and maybe I should give it a try. So I did ... Well, it's really funny but the thing I remember was that I got my ironing done. I had this cupboard full of ironing that never got done ... Sometimes I look back on the last 12 years and often wonder that I'm still alive, and think if I have to be on anti-depressants every now and then, well, it's probably no wonder.

Since being better physically, I've been able to see my mental health more clearly and realise I have been quite bleak and paranoid and not coping very well. That helped me decide to trial Citalipram again and see if there was any improvement. Within two weeks I was able to cope a lot better with stresses and generally felt less angst-ridden.

She put me onto Cipramil and one week later when I had my next appointment, I know some people struggle with anti-depressants but these actually kicked in. I could just tell by about the third day, I suddenly felt like the room was a bit sunnier and instead of getting up every day and it seemed very dark, like in a tunnel, although I still felt very fragile, I felt like there was some hope and that got increasingly better week by week with those appointments and then we made them fortnightly.

One participant initially refused to be on Lithium due to existing knowledge (unfounded or not) around the side effects that can occur from prolonged Lithium use.

I told [my GP] I wasn't going back on Lithium because Lithium, which is what she wanted me on - my uncle has been on Lithium all his life or had been and he's had a kidney transplant. And I've got another girlfriend who I met when I was in hospital and she worked for my mum - she was on Lithium all her life with bipolar and she died of kidney failure.

However, she eventually overwrote this prior knowledge around the use of Lithium due to her need for mental stability. This gave her a new 'literacy' around Lithium use that is based on her new focus on its efficacy rather than her previous focus on its side effects:

So I was paranoid about it. So she did put me on the anti-depressant but, oh, it just wasn't touching the sides. I was having mood swings. I was having anxiety attacks. I was just - and I'd get - like, go off the deep end - angry. You know all that made-up bullshit? Lithium and Serequol. God, it's bloody wonderful. Nah, stuff it. I've never been better in my whole life.

In the 1990s, Jamison (1996, p. 54) said that "antidepressants [*sic*] might be indicated for psychiatric patients, for those of weaker stock, but not for us ... our upbringing and pride held us hostage." In the new millennium, over a decade on, this view of medication does not come through in the narratives of the participants. For those people who took medication as a psychiatric outpatient or GP's patient, there is no sense of weakness at taking a medication that is prescribed also for those who take medication as inpatients. Medication, in fact, seems to restore some participants to what they see as their core self as the following comment shows:

The medication really helped me with that gnawing self doubt and that's not to say that I became the king of the world or anything, but it was just I was more in touch with my skills and abilities and knowing that I've got them and not everyone's got what I've got, and that's okay - that's a good thing, because I'm me.

It was clear that medication – when correctly given – was an accepted tool for managing mental distress to many of the women in the study and many exercised their personal agency to try medication again when they felt their wellness beginning to fail them, as the comments show:

I've also come to a point where I've kind of transcended doubting my mind about medication. If I have to be on medication for the rest of my life to prevent ever having to be in that space again, I will.

But because I kept coming back to this place of depression, I thought that I would give it a year, and I 'um'ed and 'ah'ed whether I was going to do it, and I just thought 'well, perhaps I'll try [medication] again' and I think it has been good. And I'm not sure how I'm coping with being off it. I've just had a really rocky two weeks.

These comments show that participants felt they were in control of the medication aspect of their treatment. They felt they could choose to take it or not. None of them were on compulsory treatment orders where they are required to take medication, but, even so, the discourse of the participants is one where they clearly feel they have the right to comment on their medication, choose to not take it, or choose to recommence taking it. Discourse around the negative side effects of medication was largely missing, perhaps because of the current widespread acceptance of medication as a treatment and also because medications, as mentioned at the beginning of this section, have become more effective and less debilitating in terms of side effects. Even those side effects from medication that some people would find detrimental were sometimes interpreted as a positive, as can be seen from this comment:

One of the side-effects of anti-depressants was they made me really forgetful - vague, really (laughs). Vague was good for me because, um, I had dreadful flashbacks and couldn't sleep and was agitated and hypersensitive and all of those things.

However, it should be stressed that not all participants felt that medication worked for them. Two participants with a bipolar disorder diagnosis found medication to be problematic. One participant found that she had serious problems staying awake:

Well, what happened was they put me on fucking Epilim and I just got worse and worse and worse and I was asleep all the time. X [names partner] would be at work. I'd be in bed. He'd come home, I'd make us lunch and by the time he left at one o'clock I was falling asleep again.

Another participant experienced problems because her anti-depression medication stimulated a hypomanic response and so she was put on several medications until the right one was found:

I was on about three different sorts of anti-depressants at once and I got an elevation, first elevation and it was in response to, um, three different sorts of, you know, an SSRI and a tricyclic and so forth, all at once and no mood stabilizer. Um, so that was the first one, and it was only a hypomania, but, um (pauses) elevated and, um, I noticed - and then I got another one as a result of I'd changed to Citalipram and, um, but I had had, um, elevated - when I think back, when I was in X [names South Island city] I was on Parnate which is an mono-oxidase inhibitor which causes elevation and I did get some slight elevation then.

Most participants felt that medication was good for them in the long term, as well as useful in the short term, as this comment shows:

Taking steps towards having a treatment in relation to mental illness, for my depression, I think really opened up some bits for me and I felt better than I'd ever felt internally and so my insides matched my outsides.

6.6.2 Non-pharmacological interventions

One participant, despite having two positive experiences of taking medication, seems to have been influenced by working for a non-government organisation in the mental health promotion field, a sector in which psychiatric service-user/consumer employees and volunteers, in the late 1980s and 1990s, vehemently opposed both medication and inpatient care. This may have contributed to a wish to do without medication that was not found in the other participants.

Well, I've had one other time when I took anti-depressants but, um, that was kind of, um, I did that for a little while, and the anti-depressant that I was taking was also to help me sleep because it was after a break-up of a relationship and I just wasn't sleeping and so it was a combination of the two things, and I did that for how long? Probably nine - nearly a year I suppose, and then stopped and then, more recently, in the last three years, I started taking anti-depressants. I'd tried other things, you know. I tried the alternative, complementary therapies and stuff but it felt like it wasn't working. I've just stopped taking medication and I'm trying to kind of live - I want to try and live without it and do other things, because part of being involved in the mental health field has made me, given me opportunities to look at other things that can work as well, and so I'd want to try that.

In terms of treatments other than medication, there was a positive feeling from participants towards having treatment using various kinds of talk therapy, as can be seen from these comments:

The combination of actually being on the medication and psychotherapy for a good two years has probably brought me to the place I am, but it was a slow process. I was lucky that I got a lot of paid ACC counselling.

About 1999 that was the first year I did a course called 'Insight', [a] cognitive enhancement program for women which was run by our local hospital here. It was a 12-week once a week course for women who suffer from depression and it was really helpful because it covered a lot of that cognitive behavioural stuff, and, of course, fellowship with other women sharing some similar challenges.

I've always, when I've been on medication, I've always done counselling because for my research that was what I was told, and fortunately I've had doctors who've recommended that as well.

The use of words like 'lucky' and 'fortunately' in the comments above shows that the some of the participants feel that talk therapy is an advantageous extra that is not routinely available,

and that they were in some way lucky to have been afforded it by the professionals who case managed their psychiatric treatment.

One participant's comments give a particularly comprehensive sense of the range of supports that can facilitate maintaining psychiatric wellness and lead to resiliency in the face of mental distress. Her use of the words "look I tell you - I'll tell you something for free" in the comment below indicates how clearly she has found the mental health system's illness post-diagnosis management and recovery supports to be positive factors in her life:

When I went back into the system here I had X [names female psychiatrist] who's an absolutely fabulous psychiatrist. She's just brilliant. But I only saw her - well, I didn't see her lots because what they do here is they give you a community mental health nurse. I'm lucky because my mental health nurse, X [names psychiatric nurse,] is excellent and not everyone's is ... I'm in contact with my nurse and I'll ring her if I want to see her or every now and then, if she hasn't seen me for a while, she'll ring me. I see the psychiatrist once every three months. I was going to a peer support group myself, which I've been going to ever since I had my breakdown. Once a month, all the consumer advocates and peer support people all get together for a meeting, you know - a support session. Look, I tell you - I'll tell you something for free, it's the people with the most support that get well and stay well, you know.

What is revelatory about the comment above is how different this is from the comments made about the kind of support the same participant got in the 1980s when she was first diagnosed with a psychiatric condition:

It took me months and months and months to get well and my parents were getting thoroughly sick of it. But, when you only see a psychiatrist once every three months, you don't have a community mental health nurse, you don't have any - I didn't have a psychologist, I didn't have a counsellor. I had bloody nothing. No support group. Nothing. I got well because my mother nursed me. No other reason.

Another participant, an older woman, also had quite scathing views of the talk therapy treatment she received in the mental health sector several decades ago, as the following comment shows:

So I went to see this counsellor and he was a useless counsellor. He was (laughs) he was one of the old, um, oh God, what's the guy's name? That 1970s little counsellor guy? Carl – Rogers. He was a Carl Rogers type. So in retrospect all I needed was some good CBT, cognitive behavioural therapy,⁵⁷ some good cognitive behavioural therapy, but I wasn't getting it and he didn't know what was wrong with me.

⁵⁷ CBT or cognitive behavioural therapy was developed in the 1960s by Albert Ellis and others. It seeks to challenge irrational beliefs and the replacement of them by healthier beliefs (Geldard & Geldard, 2001.)

Such negative comments about non-pharmacological interventions are few in the participant data, and belong to the historical past in the participants' narratives. This would seem to comment favourably on the development of services over time to meet people's needs.

In the mental health sector of the present and the recent past, psychological help from a registered psychologist seemed to increase wellness for one participant, as the following comment shows:

One of the things that the psychiatrist got to do, sorry, psychologist got me to do, and it was very liberating although very painful at the time, was she got me to write out a questionnaire and I had to take it back to my mother and ask her these questions about me ... and it gave me a compassion for her for the first time that, in her own way, she has tried to bring me up in a way that's her best possible upbringing she could offer me. She's trying to love me even though it really wasn't a very loving upbringing. She and her own skill-set had tried her best but it actually hadn't been appropriate for me.

Another participant found similar confidence and strength in a group for other women with the same diagnosis as her:

I've, um, done a CBT [cognitive behavioural therapy] course, a group course with a group of women which was really good ... when you see ten women in a room, and they all have similar symptoms and things, it's actually quite refreshing 'cause you think "phew! It's not just me" and just the fact that, you know, some people's experience, what they have to do to even function, is huge and I think, 'mate, I can do this.' So it actually built me a lot of confidence and although the theory stuff for me - I knew, I kind of knew it all really. That sounds so wanky. I didn't mean to say it like that. I knew quite a bit of it. It was just, yeah, and what I found myself doing in that group was, you know, some of the women would say things that I felt like I wanted to jump in and go 'what you need to do - have you tried this?' And I thought, if I can do it for other people, then surely I can actually employ some of those skills myself. So, I'm doing that.

Several participants felt that core mental health services were a positive support in their struggle to regain wellness. They use the term being 'in,' as in 'linked in' or 'in the system,' to describe feeling supported by mental health services. The participant quoted below would use mental health services again if she got pregnant. She wants to be 'linked in' to the system:

I've good experiences. I've got a fantastic GP, who's brill' and I had a really good one in X [names North Island city] as well ... People were great - like they were, the guy who saw me there was fantastic and Maternal Mental Health, yeah, they were good. I really enjoyed the psychiatrist that I had because, um, I challenged her philosophies a little bit and I think she found that quite amusing, but quite interesting as well ... If I do get pregnant I think I'm gonna definitely be in touch with the Mother and Baby Unit and say 'hey, this is what happened.' I just want to be linked in just in case.

Another participant who has attempted suicide several times in the past, found Psychiatric Emergency Services to be more useful than her GP and her counsellor. She felt that she needed to be 'in the system' and seems to be identifying her GP and counsellor as being outside the system:

I wasn't getting any help 'cause I wasn't in the system. I was just with my doctor and a counsellor. I had the counsellor before my mother died (pauses) but the counsellor, I felt, should have saw that I was getting really desperate. And then in the end I just did a big overdose and ended up in hospital and that's where Psych Emergency first met me (pauses). I had some nice people in Psych Emergency too and they were really, really helpful. They were good. So, you know, I did have some good people.

What the participant above did find was that she received different treatment when her sector base case manager changed. This again highlights the importance of supportive qualities in key individuals (in the previous section of this chapter it is a workplace manager, and, in this section, it is a mental health case manager) and the changes that can come about if that key individual leaves. It is fortunate that she still had a good mental health community support worker and access to respite care when unwell:

And the sector base - I had a really good case manager for three years and then she left, which was really - and she was just wonderful. But the next one wanted just to get rid of me and she did that. Then I have got a community support worker and I found that really helpful. And I don't know if, you know - though we have got a better service than in Australia, 'cause they don't have respite in Australia - I still think our respite system isn't quite good enough, you know. It doesn't quite meet the needs of all people.

The participant quoted above did feel that putting 'mentally ill' people together in a service was counterproductive to wellness:

I don't think, for example, ten people with mental health needs should be put in one place together 'cause I don't think that helps.

Certainly another participant found this frightening in the context of inpatient psychiatric care:

You have to start living with all these people you don't know and it's scary. I thought it would be like big white halls with (laughs) - like on the movies - One Flew over the Cuckoo's Nest (laughter) or Girl, Interrupted. I thought it would be like that. And like there'd be some real crazy people, like, shouting and stuff, and there was. There was some people that were like just completely just scary, but mostly it was just people who had, like, similar problems to me; like, they were depressed or they had eating problems or, like, mood problems. Most of them had mood problems. There was one boy in there when I was in there who was - I think he was just under the age limit to be in there. I think he was about 16 which is when you have to leave. But he was really freaky, like he'd, he'd tried to kill someone and stuff and he kept like twitching and like muttering to himself and his eyes would be all narrowed and he'd be like

clenching his fists and stuff and it was just, like, really terrifying. Like, we'd all be like (whispers) 'oh my god!' (laughs.) We'd go in our room and we were frightened of coming out 'cause it was scary but, like, most of the time people were all right.

She also found the rules in the inpatient setting difficult:

I think it was useful having them, hospitals and stuff, because, like, I think you do have, like, proper treatment and stuff, but there were a lot of things that I thought weren't very good about the way they did things and that. It was just like really annoying little things, like you had to go to bed at ten o'clock and they'd turn the light off in this room that was crafts and games and stuff. They'd lock that door like eight o'clock so you couldn't go in there, like, at night. We had to be in bed with the light off at 10.00pm, which was ridiculous 'cause I'm, like, one of those people who take ages to go to sleep and I like to read before I go to sleep (pauses.) ... We weren't ever allowed to sleep in - like, not even on the weekends and stuff. I think it was eight o'clock and on the weekends. On Saturday and Sunday, it was nine. I was just so, like, exhausted just from thinking and stuff and I was always tired. ... Oh, they were just little things that just really annoyed me but I think it was just because it wasn't my way of doing things.

Not all participants went through the psychiatric inpatient system as an environment for non-pharmacological treatments, but, for those who did have experience of inpatient treatment, it was seen as mostly positive even for the participant quoted above. After some months in the service, she did find a camaraderie with the other young people in the inpatient unit.

As, like, the year grew on, I got to know them really well. And there was another girl who was the same age as me who had anorexia as well. So we became really good friends and we kind of did, like, everything together (laughs.) And, but I still keep in contact with all of them. So, like, you make some good friends in there.

Another participant had a very positive inpatient experience due to the wide level of non-pharmacological interventions used there. This particular institution was run by the forward thinking psychiatrist and mental health sector reformer Mason Durie:

When I was 18 I went to the student counsellor who took me straight to, um, the community mental health centre which was actually a - had an inpatient part, when I was 18 and I had a full programme then. You know, they had a live-in and you had a full programme of, you know, assertiveness training, groups and relaxation therapy and, you know, the whole nine yards and that was very helpful. And they, you know, gave you a book reading-list so you could, you know, read all the books and so forth. That was obviously when I was 18 which, given that I'm 49 and a half now, was quite some time ago. It was quite cutting edge at the time. It was - it was headed by a guy called Mason Durie who - have you heard of him? He was actually the head. I mean, he was obviously very young at the time because, you know, he must have only been in his thirties, you know, early thirties. He was the head psychiatrist. You know, he was outstanding.

Several participants' comments show that they eventually felt comfortable in the company of people who had experienced the same psychiatric system and similar struggles towards mental health:

And I'd rather spend time with people with mental health issues than not because they have so much more depth to them. They're so much more 'real' people. They're not - I find other people that haven't had those experiences are often - I don't have anything in common with them. I can't relate to them.

I think the bipolar support groups are just great, I've just seen people so blossom and grow because, um, you get ideas off each other, you know, medications and things to try and, you know, all that sort of stuff, um, and also work opportunities for people going into, you know, working in mental health.

The support of peers who have similar experiences of psychiatric issues and service use in the past appears to be a crucial component to staying well, for participants, as well as a good range of mental health supports, as the following comments show:

Peer support is my absolute passion.

I have a lot, you know, of the residual bipolar things you have, like telling jokes that other people don't think are funny and, you know, that other bipolar people think are funny (laughs.) And, you know, that black humour type thing? When you're inpatients together - I remember another lady, you know, who was a bit suicidal. She actually had borderline personality disorder but I didn't realise at the time - tried to burn herself and things. And you'd go "how do you feel today?" "oh, cyanidal" and that sort of thing. Of course, we used to think it was quite amusing but people in the mental health centre thought - but we thought it was harmless because, you know, all it meant was, you know, she was just having a few suicidal thoughts. That's all it meant (laughs.)

What can be seen from these findings is that not only psychiatric services but also people who have used psychiatric services can be an important resource for women experiencing psychiatric issues.

6.7 Summary

In summary, this chapter was presented following the linear sequence of themes that emerged from the data as the women talked about their early experience of mental distress. Many began by talking about a relative with mental distress experiences, and then coming to their own pre-diagnosed state of 'madness' (or craziness) before getting diagnosed with a 'mental illness' by a health professional. They then spoke of how they dealt with diagnosis,

medication and treatment and there was a discourse of hope and a discourse of loss in these accounts that is explored further thematically in 'Chapter Seven: Getting Well - Beyond the Psychiatric 'Machine'' which follows.

What has become clear in this chapter is the fact that 'mental illness' can be construed theoretically as a socially agreed upon construct to describe something that a certain number of society's members experience in a similar way. It throws up similar outcomes for this group, mediated as this will be by other group variables such as age, gender, race and ethnicity and social class. A key finding was the extent to which some participants had a 'literacy' around 'mental illness' issues from the experiences of others in their circle of friends or family and also wider society. This 'literacy' will flow on to a self-efficacy and sense of agency that the next two chapters go into in more detail. It is a 'literacy' not only around psychiatric outcomes and the acceptability of some kinds of 'mental illness' (ie, the 'softer' ones) but also around a medication's efficacy or side effects. This notion of 'literacy' will be discussed as a main finding in 'Chapter Nine – Discussion and Conclusion.'

CHAPTER SEVEN

Getting Well - Beyond the Psychiatric ‘Machine’

Without strong emotional ties to the world, [an individual] would suffer from utter isolation and loneliness. Bernard Marchant (1990, p. 152)

7.1 Introduction

This chapter looks at disclosure issues. It finds that disclosure is not only an on-going process – extending beyond the initial first disclosure of an illness to some but not all people in participants’ lives – but that it also includes the depth and extent to which others are told of the experiences of the mentally ill person. The chapter then looks at issues of loss that include economic, social, physical and vocational losses as well as the participants’ stories of discrimination and stigma. The chapter ends with a section on recovery and accommodating change. Participants reveal endurance, pragmatism and a positive outlook based largely on their own personal qualities and the support of family and colleagues, rather than the more formal support of mental health services.

7.2 ‘Coming Out’ – Disclosure of a psychiatric diagnosis to others

A key issue for participants, in terms of family and the workplace, was the matter of disclosing their psychiatric unwellness to others. Due to the stigmatised nature of psychiatric disorders in society, disclosure was not often a simple matter. The youngest participant in the study, at age 17, had developed a strategy of not telling people in general but letting school-friends know, because they would have been aware of some of her symptomology while she was at school:

I really don’t like people to know but (pauses) you do actually have to tell some people. Like my best friend knows and my friends, most of my friends from my old school know, of course, ‘cause I had it the whole time I was there.

Several of the non-heterosexual participants identified disclosure as being akin to the 'coming out' experience of homosexual and bisexual people, as these comments show here:

So I guess part of it for me has always been a sort of process of coming out, you know, as someone with a mental illness. Even though I've experienced it just recently with the bipolar - sharing the information with one person at a time (laughs) and you're more comfortable as you take the 'mantle'! And the other thing - it's sort of unrelated, but in that coming out sense I can relate to it to with my sexuality. I'm a bisexual but I spent a number of years in several very intense long-term lesbian relationships and at that point I was very much coming out, having seemed to be heterosexual all my life. So that sense of working out something in yourself and then gradually letting the world know as you feel comfortable was already familiar.

There is a coming 'out' - there's a coming out more with my friends and relations and people that I just meet, you know, and I have come 'out' to various people with experience of mental illness, consumers that I've worked with, individually, obviously, because they've become my - you know, people that have become my friends, but I wouldn't get up in a big meeting with other consumers and kind of say 'I've experienced depression.' I have said it and I've used it some ways, with professionals, like with people who are psychiatrists and stuff, when I've been the only person in the room. I have said then, you know, "I've experienced depression" so, you know, I can kind of talk about the experience from that perspective as well as from a treatment perspective, you know, which is where they're coming from ... It's a bit like coming 'out' as a lesbian, you know. Yeah, and I do it when I think it's useful, you know, and might make a point. But if I don't think it will, then I don't it.

Another participant, talks about being 'out' even though she is not a lesbian or bisexual herself. The term has entered her everyday usage. As a former social scientist, the term has become familiar to her.

Oh no, in fact I plonk myself right in the middle because, I mean I'm really aware that people, particularly with bipolar and schizophrenia have, find it harder to be open, to be out. They find it more stressful than I have.

While those who had had treatment for psychiatric disorders for longer seemed to have had time to integrate it into their identity, participants who had not been diagnosed for long found it hard to disclose:

I only had the mental illness fairly recently and I kind of knew that wasn't a good thing to talk about with anybody because of the discrimination and the attitudes of people. I knew that that would be a closed door kind of thing.

I normally don't tell people.

At the beginning I didn't want [my husband] to tell his family 'cause it was a like 'ugh,' and particularly - what's the term? - predominantly, I do come across as this sort of (pauses) loud kind of extrovert type person, and then, I don't know, it was just like 'man, of all people for it to happen to.' I know - I only say that because I know that lots of my friends were like 'Shit, we were shocked when we heard because it was you,' you know, ra-de-ra-de-ra, and I was a bit embarrassed about that.

For those who have had a diagnosis and treatment in the mental health system for some years, there was more integration of 'mental illness' into their identity. They had a more positive experience of disclosure with their relatives once this integration has occurred, as the following comment shows:

I've been able to kind of talk to [my parents] since ... I was straight up and for the first time I actually talked to Mum about a few other things in my life. Like I never told her all the time I was going through the overeating, the bulimic period. She never knew anything about that but we were talking just after the diagnosis and I was talking about sugar and she said "but don't you think you should... energy ... etc?" and I said, "well actually, the reason I gave up sugar is because." I think she was a bit stunned - "oh... oh, thank you for sharing that." That's one thing about this whole process. I've become a lot more open; not like wearing my heart on my sleeve more a sense of being honest and upfront ... I did refer to suicidality which is not something that I would have ever told her before. It's just a sense of 'now this is me and this is how things are but I am working on recovery and, you know, doing pretty darned well at it.'

One participant was aware that she needed not to fit the stereotype of a psychiatrically unwell person in order to be accepted as someone with one, as the following comment shows:

[I]t's all in the way you dress (laughs) and the way people look at you. You know, if you walk around in your trackies with your t-shirt hanging out and you haven't had a shower for two days, well, you are one of 'those people.' You know, put your nice trousers and jacket on and go into the shops or whatever and you're not.

In terms of the workplace, there was a lot of reticence from participants in terms of telling their workplaces of their 'mental illness.' Some of them had been unwell at work or could not avoid their whole workplace finding out, but for those who had the power to choose to whom they disclosed, there was an identifiable reticence, as these comments indicate:

You don't want everyone to know.

Most people probably actually that I work with know. I've told my boss, yeah. The thing is though I think that [my boss is] not the kind of person that I would feel I can sort of say to on an on-going basis, "actually I'm not doing well at the moment" or something. I wouldn't. I don't trust her enough to do that ... I feel quite (pauses) unsupported, I suppose, and a bit cheated sometimes 'cause I feel that sometimes the words or the actions that follow it up aren't necessarily – and, you know, I do feel like in my position it's harder to acknowledge having hard times because actually I'm not supposed to ... I mean I've not said anything to my boss that's personal about what's really going on for me, 'cause I don't want to. I actually don't feel like I – and I mean I might be wrong but – I just don't feel like it's safe enough for me to do that and still have her believe that I can do the job and that I will produce the results ... I do feel there's still a little 'no-no' around it all.

The comment above shows that disclosure is an ongoing process of revealing more and more about the illness and its day-to-day impact, not just an initial 'coming out.' After an initially positive response from her employer, the participant felt that the issue was dismissed and felt she ought not to bring it up again. She learnt from this not to be so open about disclosure in future.

To cope with the impact of disclosure, some participants would disclose their 'mental illness' but downplay the illness category from a 'harder' to a 'softer' one, as the following participant did when she applied for a job at a jewellers:

I had a job behind the counter in a diamond jewellers, as a jeweller – was working nine to three – and at the interview I disclosed but I said I had depression because people understand depression. They don't understand bipolar ... what people see of bipolar is all the nutters they have on TV. You know, often just X [names current partner] and I are watching a TV programme and there's somebody with bipolar and they scream and stuff.

The participant quoted above has since her time at the jewelers come to a place of openness with employers since she has become involved in working in the mental health sector as part of the anti-discrimination campaign to counter stigma and discrimination associated with psychiatric unwellness, *Like Minds, Like Mine*. She has learned to be an 'ambassador' for people with psychiatric issues, especially for people with her diagnosis of bipolar disorder, as these comments show:

It's all about the way you look at yourself and the way you treat yourself and the way you come across to other people. You know, 'cause if you're in an interview saying that you've got bipolar disorder but you're, you know, saying the right things and you've got the right qualifications then you're selling yourself. I suppose even selling bipolar in a way and being relaxed about having it. Everyone knows I'm a nutter. I've been on TV. I've been on the radio (laughs.) It's my job.

She sees that there is an attitudinal shift in society in terms of views towards people with psychiatric issues and this gives a sense of disclosure being a constantly renegotiated act dependent on the environment the participant finds herself in and the cultural values she internalises:

They're changing you know - people's attitudes - they really are changing. You know, like when I first got unwell, you know, my parents tried to hide it.

One participant had been forced into openness with her employer when she became a victim of a high-profile serial rapist. It was unavoidable. The involvement of police and the nature of her attack meant that most people found out. She has come to accept that, because her psychiatric illness stems from a high profile rape case, it is best to be open from the start with workplace management, though she does not tell everyone in the workplace. When she changes jobs she has decided to continue the openness she has had to adopt in her previous job and seemed to have come to a place of low discomfort around disclosure:

I told [my boss] what had happened to me soon after I went to work at the organisation, and I told quite a lot of people that I worked with there - not everybody. It's never been a secret for me.

Another participant propelled herself into the national spotlight by disclosing her illness in national newspapers and on television. A certain amount of celebrity seemed to benefit her in terms of her self-esteem around her illness. She seems to have felt little stigma about having agoraphobia. This may be because it is one of the 'softer' diagnoses but may also be due to the personality of this particular participant who went on to become a university lecturer and then a Member of Parliament. Certainly the process of 'coming out' as she did nationally led to therapeutic outcomes, as did the sense of self-efficacy obvious in creating the kind of non-pharmacological treatment she needed through establishing a support group:

I went public and I had a friend who was a reporter on the free Sunday newspaper in X [names a lower north Island city] called X [names a newspaper]. Her name was X [names her friend] (inaudible) and she did a feature article on me and my finding out about this and my story and then my desire if I could set up an organisation of other people in similar positions to myself to fight for decent treatment and so on and so forth. And the article was syndicated and appeared in more than 20 newspapers around the country. It was just brilliant and so, and we gave an address and the letters started flowing in, hundreds of letters like the one I told you about, you know, 40 years. And so we had all these people and plenty of publicity and, to set up an organisation, in those days you could get government funded work schemes, fully government funded and we employed X [names an employee] another agoraphobic with great office skills to run it. We got books and articles for it, we did that, we took people as much as we could. Sometimes four of us would leap into a car. One of us would be competent to drive in the country, the others would be terrified, and we'd drive to X [names a lower North Island city] or something. We made TV programmes, we did a lot of stuff but it was very, very hard to hold together and it was kind of reliant on the fact that, because I hadn't allowed my houseboundness to stop me but I was prepared to try anything. But you know, it was difficult but one of the first things that happened was that my own skills started to improve. I actually became less scared and once you can reduce those anxiety levels and do more things then you get into this kind of (inaudible) so I started to actually therapise myself and also we

managed to persuade a group at X Hospital [names a North Island psychiatric outpatient service] to run a cognitive behaviour therapy trial thing with us and that was a weekend and that was excellent and I learned the principles then of how to talk to yourself. So I started to improve.

7.3 Identity loss, discrimination and stigma – Negative social experiences of being ‘mentally ill’

7.3.1 Identity loss

Some participants experienced painful feelings about not being able – due to ‘mental illness’ – to achieve everything in life which they would have liked to have achieved, as the following comments show:

Yeah, I could just never face [teacher’s college] again ... ‘cause I was so unwell all year without realising it ... I just couldn’t imagine being in a classroom full of 30 screaming kids. I couldn’t cope, eh? I guess because I was unwell my self-esteem was shot. And it was like, well, what do I know anyway? Why - how can I be teaching kids? I don’t know what to teach them. I don’t know anything. That type of thing.

I found, after my mental illness phase, that I was unable to write. I couldn’t string a sentence together.

You feel very powerless because I can’t, you know, I can’t work like I used to. You know, before, if I wanted money I could always work. Now I cannot. It’s a powerlessness.

Another participant felt so awful about the impact on her identity and her abilities of being ‘mentally ill’ that at times she wished she did not exist anymore:

My whole life was one big fuck-up and my whole life I was unhappy and I wanted to die. I’d go to people’s funerals and I’d be wishing it was bloody me, thinking why isn’t this me? All these people are upset, you know, and it could have been me. And I’m sick of living my life wanting to die.

The ability to function successfully in society and do socially normative activities for these women is clearly a core aspect of a sense of social identity.

7.3.2 Discrimination

One participant identifies as lesbian and had a ‘literacy’ around oppression in terms of sexuality, in that she was aware of discrimination around homosexuality. She makes a

revelatory connection for herself between this kind of oppression and the oppression that can be generated around her diagnosis of 'mental illness,' as this additional comment shows:

[It's] a bit like the mental illness equivalent of internalised homophobia.

Several participants had experiences of direct personal discrimination, or generalized discrimination, in their workplaces. One participant overheard at work negative comments made about bipolar disorder, a condition she has been diagnosed for, as the following comment shows:

Something came up once at a staff meeting where there was talk of a certain child whose parents had broken up and there were difficulties with the parents arguing. The other team leader said to me "oh, she's bipolar isn't she?" about the child's mother. She said "oh, they're crazy anyway".

Another participant felt that she was unable to return to work because of discrimination and had severe obstacles put in place due to barriers to occupational rehabilitation:

I was off for a month on sick leave but then it was nearly impossible to go back 'cause work made it really difficult for me (pauses). And they were really unsupportive of me, just wanted to get rid of me. They just wanted to get rid of me anyway (pauses). So that was really difficult.

One participant experienced discrimination vicariously due to her partner's psychiatric unwellness. She feels that this experience, along with homophobic discrimination, led towards her own mental health problems – depression and anxiety:

I discovered that when I got together with my girlfriend I lost virtually my entire circle of friends and most of that was because one or two people who knew that she had mental illness spread it around and obviously put a really bad spin on it and I had people asking me 'are you safe? Do you know what you're doing?' And one of the things that led to my own mental illness was that I lost most of my friends and I also lost contact with my family who were very homophobic so there was a mixture, when we got together, of people didn't like X [names girlfriend] because she had mental illness and people that didn't like us being together because they were homophobic. So yeah, that kind of social ostracism was pretty much what led to my own experience.

7.3.3 Stigma

The following participants' comments are clearly enunciating that psychiatric problems equated to the stigma of vocational loss to them:

That's the other side of mental health - is that you wind up, you know, not having a huge income. If you can't work 40 hours a week, you know.

It's changed the way I work because now I only work part-time ... all of a sudden, you're in the mental health trap.

Basically I got depressed when I was 18 and I was at teacher's training college and, um, I was off for about six months but when I went to go back I didn't want to go back. I didn't think I could cope, you know ... when I left school I didn't know what I wanted to do but I liked school so I wanted to be a teacher, but I think because of my lack of ability to, um, handle stress I wasn't able to do the, you know, finish the training (pauses.) And, um, so I never ended up doing the career that I really want, you know, would have liked to have done ... if I could have done it I would have liked to have done it ... but I tried again to go back and do it, you know, since almost 11 years but again I wasn't up to, um, I wasn't up to the training ... I gave up my jobs because I couldn't do it anymore.

That's probably what's highlighted the whole thing about having what we refer to as a mental illness, or having depression, you know, in terms of my career. I know that I can't, I actually can't do those kinds of jobs.

Psychiatric illness has brought these participants to a career plateau where they cannot go on in the demanding work roles and may need to down-size their career. Career plateaus are usually reached when one has arrived at the top of one's skill level or some kind of 'glass ceiling' is imposed but for people with psychiatric disorders they discover that a kind of ceiling is reached based not on their skills but on what they can cope with and still stay well. One participant is aware of her limitations at work as a person with a psychiatric illness. She struggles being a manager in the public eye:

It would really probably be in the last couple of years when I've taken on a more national role which is kind of in the upper echelons of the organization, and I think that it's, they're very demanding those jobs and they're the kind of jobs where you have to be 'on' all the time and being 'off' is not a good look. And you're in the public eye, there's lots of media stuff, people – you are expected to represent the organization in particular ways and yourself in particular ways, and there's a lot of travel involved and there's constantly on and off aeroplanes and constantly meeting people and schmoozing and, you know, talking about how fantastic the organization is, and finding out where the organization might wanna go, and talking about possibilities with people, and, oh, it's just not me. I realize more and more that's just not me. I don't want to do that and, yeah ... So, um, yeah, if I could choose, I'd choose not to have it that way.

High pressure jobs seem to be difficult for the majority of the participants, except the participant who became a Member of Parliament. She gave no sense of why she was able, unlike others in the present research, to cope with the pressures of her position. Another participant, not able to return to her usual high pressure journalistic profession due to

psychiatric illness, found herself in a period of unwanted career transition and considered down-sizing her career. She tried out a series of other lower status jobs that she was surprised to discover she found hard to do. The stigma this created in her affected her sense of vocational self-esteem:

It was like my head had been kind of – all the stress had kind of scrambled my brain and I couldn't – I was writing essays for quite basic courses and could barely put a sentence together ... I struggled to put sentences together. I did a series of awful jobs like working in a fabric shop. I had some horrible experiences actually and it was really like work that I hadn't done since I was quite young, that kind of student summer holiday type jobs. I'd been used to, by that time, working in jobs where I had quite high status as a journalist and I, it was really quite awful to be in a shop, treated like an imbecile and I should never have taken a job in the shop because the guy asked me at the interview, he said "are you married and do you have children and how old are you? And I normally like to employ women in their sixties because they're less trouble and they're not going to go off and get pregnant". (Laughs.) I mean he was outrageous and I kind of wish I'd just walked out on him. I should have but I desperately wanted this job because it was in a fabric shop and I'd thought that that would be something I could do because I liked working with fabric and sewing and stuff. I thought it would be nice and simple. It would be a nice simple little job, a nice pleasant job working around nice fabrics - I thought that would be a nice thing. It was sort of like working in a flower shop type of an idea.

For only one participant, not only career identity, but also identity as a woman in terms of physical attributes, was hindered by psychiatric illness and the side effects of necessary medication as these comments indicate:

The other thing I did was when I went on the mood stabilisers I gained four stone, four and a half stone actually.⁵⁸ I went from 57 kilos to 89 kilos which is a huge physical change. I changed from Epilim to Topomax and I lost ten kilos, yeah. But it's very hard to lose the rest of it. I look completely different to the successful person that people used to see. Now when they see me I look like a disaster, because they remember me as a person who used to be a - I think in 1994, um, I earned \$88,000, um, and I weighed 57 kilos. You know, people who saw me in 1994, and seeing me now, at, you know, 84 kilos and on an invalids benefit, think that I'm a definite - definitely not successful (laughs), you know, and I don't have any of the – I don't dare go see – I don't – I avoid any of the people I ever knew before. Now I think I get less than \$10,000 a year because of my benefit. The thing is I've been so 'had it' that I haven't sorted out my benefit so I haven't actually had a benefit for the last 14 months. I mean, yeah, you wouldn't choose it, would you? You know, I'd rather - I've got a whole house full of 57 kilo clothes (laughs). They're still - I bought classic things. I mean I'd still be wearing them if I could (sobbing). It's a real pain-in-the-arse thing to happen, isn't it? They haven't gone out of fashion. It's really hurtful, um, not being able to see the people that you knew, because they just – I'm just – to them I'm just a big fat slob – clinically obese I am. (laughs) ... a guy I used to go out with, um, he's still friends with me, and, er, he said "oh, it's funny how things have changed for

⁵⁸ Mond, Morice, Owen and Korten (2003) note that significant weight gain can accompany long-term use of psychiatric medications. This can occur because carbohydrate is not metabolised properly or because the stimulus to feel full does not occur when eating due to the effects of the medications.

you since you lost your looks" ... he just said "things are much different for you, now you've lost your looks." Letting people treat me different and – (long pause) (crying). He hadn't seen me for a while.

One participant, a social worker who has worked in the mental health and addictions fields, was able to generate a personal theory of alienation and discrimination to explain why there is often a negative response towards people with psychiatric illness and other differences in society. Her theory was that if people deviate from the norm they become ostracized and discriminated against:

Society doesn't necessarily nurture and encourage everybody to be themselves because if we are a little bit different, and, say, it could be because of mental illness, we don't fit within the norm. We're a little bit on the edges and so we're not necessarily valued. You know being a lesbian and a drug addict and, um, experiencing depression, you don't kind of fit in the norm and so it's very easy to just stay in the margins and not achieve and not contribute. I think society needs that sometimes to maintain its status quo of the normal, or the mainstream of the silent majority or whatever they are.

Other participants had less theoretical analysis but clearly enunciated how alienated they felt, not only from 'sane' people, but also from others with psychiatric issues. The following comments show clearly the delineation they feel between the 'softer' and 'harder' diagnoses, for example depression as opposed to bipolar disorder and anxiety as opposed to schizophrenia:

Um, I have to admit when I was in X [names North Island city], when I was first experiencing - just thinking 'man, I'm not coping, I'm not sleeping, this is scary,' I went to a, um, an adult mental health service and it was flippin' scary this mental health service and I have to admit I sat there thinking 'this isn't where I should be,' like I just looked round the waiting room and thought 'No! Why am here?' ... Far out! It was dingy. It was – (takes a deep breath) it was just, there were long-term mental health service users and, um, people smoking. Not that I care about people smoking, but it just had that stench of (pauses) – I don't know, it's just that it really (pauses) – maybe it was the space that I was in. I was frightened and so anybody that walked in – I was like 'shit!' and thinking 'I don't want to look at them.' So it was kind of all built into that. It was related to the whole stigma thing. It was like me, confident, you know - what the heck, I work in this area. I'm supposed to be the person that supports these people. I'm not supposed to be the person sitting in this seat. So there was quite a bit of stigma, you know, internalised stigma stuff going on as well.

I went to X [names a community mental health rehabilitation centre], a community rehabilitation service which was awful. It made me want to kill myself, not literally but –. The people that were there were like these stereotypes of people with mental illness. They were kind of like people who had, like 'give up hope all ye who enter here' and I thought 'My God, is this what I've come to? Is this where my life has led?' I really tried hard. I would sort of force myself to go every now and again and each time I would come away feeling more depressed than I had before.

The following participant's narrative of her experience clearly shows that she has a sophisticated analysis of the debilitating and life-threatening nature of even the so called 'softer' psychiatric diagnoses such as anxiety and depression:

Those people who are stuck in their homes for 40 years aren't stuck in their homes anxiety-free, they're stuck in their homes in terror. Do you remember the woman a couple of years ago who died and she allowed herself to starve to death rather than allow someone to come into her house? I think she must have had (pause) what's the thing where you, obsessive compulsive behaviour. That's right, yes. I think she must have had OCD and wouldn't let people into her house and wouldn't go out herself so she let herself die (pauses.) And one of the outstanding issues for me is that there are no plans to offer a national phobic service. They are a mild mental illness according to the Ministry of Health and they're not going to become – it's only severe that are covered.

7.4 Paths to recovery and accommodating change

The women used the term 'recovery' to describe their experiences of symptom-relief and better psychiatric functioning. They did not use the term 'recovery' in the sense of an absence of all psychiatric problems. Rather they incorporated a sense of resilience towards their condition, as well as symptom relief, into their narratives. This idea of resilience exists in the language of the psychiatric profession but has not entered the language of these women. The word 'recovery,' seen as an ongoing process incorporating resilience, has, however, become part of their vocabulary. Even though their 'mental illness' was, to them, biologically based, participants had a strong sense of personal responsibility for their own 'recovery' as these comments show:

This is the circumstances that I find myself in and I've got to work my life in such a way that my life is manageable.

So you accept it and work with it. I just decided that, you know.

A focus on not 'giving up' no matter how hard it got was the difference between 'recovery' and long-term disability for some women:

And I think if I wasn't so motivated in my own recovery, I may not be as well ... I don't really look back on my journey as being negative. It's kind of like I know how I've grown out of it.

I think I sort of knew, really right from the start, I think that I absolutely knew that I could give in to these phobias and stay at home forever or not (pauses) and getting

up was sometimes such a terrible struggle that I always wept and so there was something inside me saying 'you cannot give up.'

There was a strong sense of acceptance of themselves as people with 'mental illness' from some women. It seemed to depend on the comfort given them by their spiritual beliefs.⁵⁹ This seems to be reflected by several of the participants' stories of survival despite severe psychiatric unwellness:

I actually have a spiritual master who's an enlightened being – a wonderful person who, um (pause) ... it's not a religion and that's what I really like. It's just about (pauses.) I don't talk about it very much 'cause I find it hard to explain ... And basically what he's taught me is that, apparently, we are all this amazing Being of Love; it's just well buried. And he just works with us to recognize – for us to recognize that in ourselves, and because he has, kind of – now what's the word for it? – transcended that, and he is just this most amazing being. And, um, I went to stay at his ashram when – not long after I'd met him when I didn't fully understand who he was about, but it was after Mum had died and I was just looking for a kind of spiritual retreat, I suppose. And I went up to where he was staying and had never felt so amazingly unconditionally loved and accepted by him and this, um, friend of his that he was living with – from these two people that I didn't even know. And it was like that experience just changed my whole life because this was something I'd been looking for that had never been offered to me before.

I hadn't been to church for a long time and when I started to get better I wanted to go back to church ... it's why I'm still here, honey. I'd be dead. I have very firm beliefs when it comes to faith, my faith with God, and I believe strongly that he gave me this illness for a purpose and that I couldn't do the work he would want me to do if I didn't have that personal understanding.

People might think about me 'oh, another phase. She converted and then went to X [names a country that is the spiritual home of a world religion] and now it's all over.' People can say that if they like but it's actually not the case because it's something I live. I just don't chose to wear it on my sleeve ... I would really pray hard each day ... [and] I was really working this 12-step programme which, as I say, for me has worked but only because I work it.

Spirituality is a strong enough component of the 'recovery' of two of the participants in this study that they see it as having saved them in a sense from their 'mental illness.' If we begin from the theoretical position of the present research that human beings are interactive beings exchanging symbols with their social context/others through discursive practices in order to make meaning of their existence, then religion or spirituality can be seen to aid in

⁵⁹ Former New Zealand Mental Health Commissioner and mental health service user Julie Liebrich (2002) talks about both mental illness and spirituality being an opportunity to experience the 'self' and that mental illness can lead to spirituality and thereby sometimes to mental health.

the meaning-making process in that they free⁶⁰ people “from the burden of trying to improvise [their] own moral code” (Heller, 2008, p. 152.) This may bring relief from existential angst as well as providing a sense of community to psychiatrically unwell women who feel socially isolated. Other participants expressed a more secular view. One participant utilised ‘pop-psychology’ in the form of self-help books:

That’s how I kept myself well, all those years, because I knew about the self-help thing, and I’d read the books.

Other women found complementary therapies useful as these comments indicate:

Tai Chi is also very calming so - slows the breathing down and balance.

I think that not doing something creative and not doing yoga, which is quite meditative, is really bad for my mental health.

Most of the women in the present study felt that they had been given a new strength and clarity in life that they could not have had without experiencing mental distress and being diagnosed with a ‘mental illness,’ as the following comments show:

So all the experience and stuff that I’ve had, although if I had my time over I’d chose not to go through it, it’s actually very beneficial to other people and to my job.

It has changed my view on things. I’m not so concerned about, you know, making everything completely okay. It’s had a huge influence and, um, (pauses) I’ve seen the change in myself just in terms of, you know, I would have things planned two weeks beforehand and I’d have it piled into a suitcase at the corner of my office just ready for that workshop. And now I’m a little bit more relaxed, you know. I’ll try this and if that doesn’t work, maybe I’ll try this sort of thing. I think it’s because the whole anxiety can just throw you like that and I have coped in some pretty fricken scary situations – internally – like scary stuff going on for me ... And I think that if I can do that, then I can do lots of other things. So I think, and this sounds so cheesy, and I hate it when people used to say that, but I think it’s actually made me a stronger person. I’m saying, you know, if I was younger, I’d go ‘I really need to have an episode, and experience of mental illness so that I’m a stronger person.’ (Laughs.) But looking back it’s like, man, if I can pull through that kind of stuff, then I must be a pretty strong person or, you know, have strong supports around me and stuff.

One participant talked about strength and recovery and the belief that she felt she has come out of the other side of her illness experience, which was based around post traumatic stress disorder as a result of a specific traumatic incident:

I’m an infinitely stronger and more confident person than I was ten years ago, because of what I’ve been through, probably. Yeah, and in fact it’s very hard to map out your life and know how things may have changed. But when I see where I am

⁶⁰ Comfort with ambiguities and acceptance of them is hard in a world which believes in progress and requires a hegemonic centre to function structurally.

now, I'm very happy with where I am and where my life is now. It's been a difficult road to get here and it's hard to say whether that determination would have come if I hadn't been attacked.

Another participant felt that having status through her study and her academic work position brought about a crucial sense of self-efficacy to cope with the effects of psychiatric illness:

I think doing well academically was very helpful because I would have had really low self-esteem. Just [been] somebody who has trouble getting out of their own house, you know.

Another participant found that knowing about the lives of others who were struggling more than her with mental distress, or who had even given in to their psychiatric illness, provided a spur to her to keep going and not give in herself:

I later knew an agoraphobic who had given up and that really reinforced in me, 'cause there were people who were writing to us when I actually went public about my own story, they said "look, I've been housebound for 40 years." Stories that made us cry actually.

Some women found that learning their limits at work helped them not relapse and assisted in their maintenance of wellness as these comments show:

And then it was a day or two later that I thought I'll give my notice. Even when I get over this breakdown I'm going to have new medication issues. I'm going to have stress issues. I'm going to need time to rebuild.

I'd sort of like, well, I thought if you work full-time you'll get sick, type of thing.

Several women used the notion of 'having a life' or 'being in the world' to give a picture of themselves in recovery from 'mental illness' and making positive gains for themselves despite it, as the following comments demonstrate:

It's just been the last couple of years that everything's starting to - actually since I broke up with 'X' [names an ex-partner she lived with] things have started to get better, since I started going to 'X' [names the mental health community-based rehabilitation service she volunteers at] and getting involved and having my own life and stuff.

I've learnt how to take my space in the world – that there's not a flashing neon sign that says 'loser' or 'junkie' or 'drug-fucked bimbo' that precedes me as I walk into a room, no matter what my head might tell me at times ... Insides matched the outsides in that I'm more able to see myself as the world sees me ... I wasn't walking through wet concrete all the time. I could keep up, and that was like a breath of fresh air. Since that time life's not perfect. Things do go up and down, but I'm a lot more aware of my mood and I'm much more aware of when I'm not looking after me and my mental health.

7.5 Social support

Lizzie Simon, writing about her experience talking to people across the United States about their experience of bipolar disorder, says the following:

Everybody has stories about alienating their friends. Everybody has stories about exhausting their parents. Everybody has somebody who loved them unconditionally through the whole damn mess. Everybody has stories about being misdiagnosed, mistreated, misunderstood, and disrespected by the medical community. Everybody has spent long stretches of time as zombies waiting for medicine to work ... Everybody has some people they tell and some people don't tell. Everybody fears stigma. (2002, p. 209-10)

While this is not entirely true of all of the women in this study, nevertheless aspects of all of these experiences described above by Simon have been related by participants in their interviews. Asen (1997, p. 100) notes that “how those near and dear, no matter whether family or close friends, respond to serious illness does have a major impact on the ill [person].” Participants clearly were aware that their mental distress impacted on others around them and, also, that others’ approaches to their mental distress could impact their own level of wellness negatively, as this comment show:

I’ve recognized, of course, how my unwellness has impacted on relationships, and the way that my relationships have impacted on my unwellness.

What is interesting about the participants’ narratives on social support is the lack of data on friends in general. Some do mention friends in their narratives but not specifically in terms of social support. There have been examples in the pages above of a reporter friend helping one participant get her story into the media, of a bipolar support group offering a sense of belonging to an older participant, and of an inpatient setting providing others with whom to bond for the only school-aged participant, and of spiritual communities offering support. However, there is no wealth of data on friends who were already in the lives of participants who provided social support. There is a lot of informal talk in society about the importance of a woman’s friends but there is only data on family and partners, and a special mention of M•ori, in this section on social support. The impact of managers and work colleagues is to be found in Chapter Eight on workplaces. The role of people in the mental health sector in terms of supporting the women has been presented in Chapter Six. This silence around

friends from the data may reflect a greater social isolation in the women researched than in the mainstream population. Or it may reflect what the women felt was significant to convey in the short time provided for telling their story by an interview process. Alternatively it may show that, as the saying goes, blood is thicker than water. For whatever reason, friends are largely absent from the data.

7.5.1 Family and partners

Some family members' behaviour left participants in the present study feeling belittled or misunderstood as these comments show:

When the first episode happened, my mum was staying with me – they live in Australia – and she was shit – like she – I think she's always seen me as sort of the confident daughter and it was almost like "oh, darling, you'll be fine." You know, "you'll just move through this" and ra-de-ra-de-ra and, you know, "move on with it and" – which is quite surprising 'cause I'm someone different and she actually added to my difficulty, I think, after the birth ... I kept saying to Mum ... like, "for fuck's sake, you know, I'm not choosing this. This is something that has happened to me" ... Um, it actually made me angry rather than feeling sorry for myself. It made me pissed off and one of the things I said, and I kept saying to Mum and whoever else I talked to, was that this is not a choice. I'm not choosing to act like this so that I get attention. You know, if I could wish anything it would be not to be feeling these things and so it actually irritated me, like for fuck's sake, you know, I'm not choosing this. This is something that has happened to me. I don't know why but let's just move through it. Well, I say that now – I probably wasn't saying those words but it made me angry. That was the feeling.

Oh, he [ex-husband] was just, um (pauses) abusive and his attitude was that he wasn't going to have children with me 'cause he didn't want to breed with my kind, which is someone who had a mental illness. And I just got put down all the time. If anything - any decision we made or anything happened - it was always my fault because I was sick.

You know, and I've had quite a bit of contact with my family; we all live around here. But still feel very much kind of not understood.

In terms of my mental illness it always felt like a brush off from [my father] and his wife. Ugh, where do I start? (grimaces.) I just was bawling to my Dad on the phone and said "look, Dad, I'm really sorry I don't think I'll be able to come," and he was really supportive but it was almost like a brush-over: "okay love, you'll be alright love, okay then, see ya." I mean, he's good in a professional role, but you sit in a room with him and you can see him feeling uncomfortable. I think he's frightened that I'm either going to burst into tears or go "Dad, tell me about you, the real you" and I don't even attempt to do it because I don't think he's capable of doing it whereas X [names step-father] talks about feelings and that's what I've grown up with. I remember Dad saying "we'll come up and see you when all of this is y'know," and I was thinking when all what is y'know? He's that sort of person so I don't disclose a lot to them. X [names her father's wife] annoys me. Her husband left her. She brought up two children. "Well, you'll just have to get on with it," she said to me on the phone one day and I just bit her head off.

Her really good friend is a midwife and it took her and another woman – a lactation consultant – to say “hey, look this is actually serious,” and so she softened a little bit.

Rack (1982) has surmised that some family members are not supportive because of the stigma they feel, as though genetics and even the family environment will be seen as culpable for the psychiatric unwellness of the participant and this would bring shame on them. Nevertheless, in this study, despite the comments above, most participants were able to give key examples of good experiences with their families and partners. This was an unexpected finding since I had assumed that more familial and relational dislocation would have occurred. Again, this may have been an assumption based on my own cultural exposure to psychiatric issues and family reactions based on my own absorption of negative narratives from films such as *Girl, Interrupted* and books such as Millett’s *Looney Bin Trip*, as well as my own experience of feminism and the mental health consumer movement in London and New Zealand in the 1980s and 1990s. At this time, the family was deemed a hostile battleground for women’s rights and the rights of those diagnosed with a psychiatric disorder. With the demise of the hospital era and the advent of care in the community (plus greater openness in western society about psychiatric disorders, especially depression and anxiety disorders) it would seem that many of the women in this study, whose experiences occurred in the 1990s and the new millennium, had much more positive family experiences than may have been the case in the 1970s and 1980s.

For most participants, family members and partners have been positive supports as the following comments show:

Along the way, people have encouraged me, mentored me, supported me, sat down with me, you know, and helped me write application letters for jobs or application letters for university, um, and just shown me how to do things a little bit differently.

She’s [female partner of five years] incredibly supportive of me, and will basically support whatever I want to do. She’s also very acknowledging of the fact that I have this experience and, you know, just works with me on it really. You know, she reminds me to breathe quite a lot (laughs), those kinds of things. I mean, that’s just a small example but that’s one thing that I always remember about her. She’ll go ‘Are you breathing? Have you been breathing?’ and no-one else has ever said that to me before, but she certainly has and (pauses), when she’s being not worried about me, she’s fantastic because she can give me lots of sort of more impersonal support, if you know what I mean. But she does also worry.

My parents are really supportive.

My partner is very supportive of me and my ongoing healing process. I'm a person who has experience with mental illness. It's not the only bit of me. There are many bits and they all make me up to be who I am and they're all okay. So she's supportive and, um, we have a good life.

Um, my partner was fantastic. He's worked in mental health as well. He worked in child and adolescent mental health so he - rather than it all being new for him and him going, 'shit my wife's freaking out' - he was, like, 'you're going to be okay, it's just' - and he had all the - he's fantastic - he had all the right things to say but not in a patronizing way, in a therapeutic way really. He was great.

Not everyone got the support from the family member they most expected it from. For example, the following participant's comments show that she was surprised to find that it was her father who was most supportive and helpful after she was attacked and subsequently suffered from post traumatic stress disorder:

[My father] was the first person to say to me "this isn't something that you'll be over in a few weeks," which really shocked me because Dad, at that time, wasn't really known for his sensitivity and was, you know, close to seventy at the time. But my relationship with my father became a lot closer after the attack, whereas previously when I talked to my parents I always talked to Mum and hardly ever to Dad. You know, 'hi Dad, is Mum there?' But he was one of my - he was a rock the whole time. He really was. Oh, Mum was lovely and very caring and all the rest, but actually I think it was too difficult for Mum in some ways. It broke my father though. It really broke my father. It was heartbreaking to see how he was affected by what happened to me.

Another participant found that her partner was really supportive despite her challenging behaviour towards him and the fact that he did not like the kind of work she now does with other people who experience psychiatric illnesses:

X [names current partner] hates my job but he's wonderfully supportive if you get what I mean (laughs.) He hates what I do, but if I ever need to talk about something or anything like that he's really good ... He hates me working in mental health and worries for my safety ... He thinks I'm going to get hurt by a client ... he's 60+ years old and old-school - One Flew Over the Cuckoo's Nest - and anyone with a mental illness, you know, is violent ... I can be violent when I'm unwell. I can yell and scream and hit him (laughs.) I'm terribly ashamed of that (laughs.)

Parents were more supportive than some participants expected, as the following comments, with words like 'unbelievable' and 'unreal,' show:

My parents are just bloody unbelievable. When Mum - when I got sick this last time I was in hospital for three months. My mother flew up from X [names South Island city] twice. They don't have the money, you know. They don't have a lot of money. She was absolutely wonderful 'cause poor old X [names her current partner] didn't know what the fuck was going on and he really needed support.

My step-father, um, has experience of mental illness. So it's been a - you know, it's been talked about in our family openly and it's fine ... My step-father's actually unreal. Like, he's been a - he's been fantastic ... when I talked to him on the phone it was wonderful because he was just so empathetic, you know – the difference between sympathy and empathy – he knows. He said "sweetheart, I'm with you. I hear you." He goes "but you will make it," and it was that sense of, well, if he can do it, I can do it. You know, and just some little strategies to – oh, and just telling me that he loved me and that sort of stuff really ... With X [names her step-father], because he'd actually experienced some of these things and experienced the techniques that helped him move through it, I believed him more, whereas, when the professionals were saying "it will be okay," it was, like, how do you know?

The second participant's comments above clearly show how important this kind of support can be from others in the family who have experienced 'mental illness' themselves. She talks about being heard and someone else knowing what it is like and this had a deeply therapeutic effect for her. Certainly other people in the family or partners who have experienced 'mental illness' themselves were deemed to be very supportive people, as the following comments demonstrate:

I've got a partner, X [names female partner.] ... She lives just round the corner. She is supportive 'cause she's been there herself. Yeah, and she's very good.

We've both experienced mental illness and, like, we're both interested in each other's work and have got lots of opinions about things and, you know, and we both provide some problem solving to each other when necessary and that kind of thing.

What seems to be true for all of the women in this study is that they all experience a greater or lesser denigration of the 'self' through the social experiences and stigma they experience around having 'mental illness' but that this is always mitigated by other relationships and positive self-regard that develops from positive social interactions, particularly those that provide nurturing and an ongoing sense of affiliation to the world. Lund (1997, p. 24) makes the point that the most effective helper must be a particular person – "as Lennon put it ... 'somebody, not just anybody.'" Lizzie Simon (2002, p. 67) recognises the importance of this when she says of her boyfriend: "I look at him and I think, there's somebody who will recover if only somebody will stick by him through it all. I decide to be that person."

7.5.2 Social support by M•ori

Though the participants were predominantly of European origin and only one had some M•ori ancestry, there were several women in the study who had M•ori managers or relatives who were aware of their psychiatric diagnosis, and three women who commented about the impact of M•ori upon them. These participants found their interactions with M•ori to be overwhelmingly positive. To cite a couple of examples, one participant was helped by a M•ori woman at work who was very sensitive and took the time to listen to her:

However, we had this fabulous woman who was the M•ori director who just happened to come into the office that afternoon and my boss wasn't there and I didn't know what to do. I knew that I was in an absolute state. I was beside myself. I just didn't know what to do, and I said to her, "I really need to talk to you about something that's happened" and she said "oh, yes, that's cool" and so I told her and she was just devastated ... and she said to me "leave it with me."

This woman then went on to intercede with other managers so that they were more sensitive to the participant's needs. Another participant had a M•ori manager who used a wh•nau support approach at work. She found this very valuable:

X [names manager] is part-M•ori. And she just has the whole kind of wh•nau support (everyone-treats-everyone-the-same, um, people-with-mental-health-issues-are-no-different-to-everybody-else) kind of thing.

Another participant's husband is M•ori and she found him to be very supportive:

He's M•ori. I think it influenced it just in the nurturing side of things – like it was all about support and family and, you know, sharing it within the family and things ... I was a bit nervous about him telling his family and he just sort of said to me "babe it's wh•nau," you know, and one of his sisters, um, has experience of mental illness and she is quite often quite unwell, um, sort of probably in the high-user end, and so the family are actually really open to it. It was sweet. They've been nothing like – sister-in-laws were sending me books around good sleeping habits.

M•ori in most of these accounts show that they value talking through issues and have a caring accepting approach which focuses on how they can help the person with experience of 'mental illness.' This is not a lot of data on M•ori in the lives of the women in the study, and these comments about M•ori differ little from comments about support from P•keh• family. These participants, however, highlight the caring, sensitive and wh•nau/h•pu-focussed⁶¹ attitude of the M•ori with whom they shared details about their 'mental illness.'

⁶¹ Te Reo M•ori for family and community.

Whenever participants have expressly identified someone as M•ori in their narratives (and, no reader should assume that people not identified by ethnicity in the women's narratives are necessarily P•keh•), the account has been about the especially helpful nature of that person's interaction with them and the proactive help they have offered. M•ori have a wh•nau approach to dealing with people which differs from P•keh• approaches. The importance of a wh•nau approach to dealing with people – whether family or employees – is indicative of the more collectivist nature of M•ori society (Cushman, Laidler, Russell, Wilson, & Herbison, 1991.) As Ball (1971, p. 158) says “the M•ori concept of the extended family and its child-rearing practices differ from those of the European.” Also Brislin (1990, p. 13) notes that while individualists seek to “pursue their own goals ... collectivists are willing to subordinate their own goals to those of a group.” Without making more of this than it warrants from the data, it does appear that participants in this study who named their M•ori connections feel that they have benefitted from the collectivist confidence of M•ori (Walsh, 1969) in terms of their strong belief in supporting wh•nau or those they perceive to be connected to them in a significant way. The following whakatauk• sums up this M•ori sense of collectivism: Naku te rourou nau te rourou ka ora ai te iwi. (With your basket of knowledge and with my basket of knowledge we will succeed.)

7. 6 Summary

Women can be seen in this chapter to be responding to the social impact of having undergone a ritual of naming and labelling. They have undertaken a rite of passage living with internal struggles with new identity formation as a person with ‘mental illness’ and responding to experiences of the medical interventions sanctioned by the State to deal with such illness. How the women expressed their discourses of hope or loss was largely dependent on their interactions with others. Other significant actors in the plot of their new life as one of the psychiatrically unwell in society (as well as a lifetime of messages about psychiatric disorders internalised from social interaction prior to diagnosis) produced a

viewpoint for the women in the study that led them to feelings of loss as well as of hope and strength. Adaptation and learning to endure and rebuild usually occurred after an initial shock of loss though it is by no means solely a linear, single episode process. Women gradually learned to accommodate change brought about by their diagnosis and treatment into their lives.

People can be said to utilize one another in order to stabilize their inner lives (Hirschhorn, 1990.) Good mental health outcomes rely not only on good health services but also on wider social service agencies that support recovery and inclusion in the community and society in general (Ministry of Health, 2004.) New Zealand mental health policy in the new millennium has been strongly influenced by the strengths-based model in which recovery through community support and reduced but targeted inpatient care is believed to best serve the needs of people with psychiatric problems (Ministry of Health, 2002.) A supportive caring family, a sense of connectedness (Haines, 1987), attachment to networks within the community, access to support services, positive self-related cognition, an internal locus of control and involvement with a significant other person (whether it be a partner or a mentor) are all seen as being protective factors influencing the development of psychiatric issues in individuals (Ministry of Health, 2002.) Many of these can be seen to be operating in the lives of the women in this study through their comments in this chapter. Even when inside the psychiatric 'machine' of diagnosis and treatment, as Chapter Six showed, they also experience more of an internal locus of control than was previously available to the psychiatric service-user when interfacing with psychiatric services. This would appear to spread beyond the 'machine' and extend into their world outside psychiatric services. What is lacking though is a sense that friendship has helped the women through this transformative time. The lack of data on friendship was clear. Family seems to be the main support, judging from the participants' narratives, despite the quarrels and conflicts that families so often contain. Māori are also signalled as having an empathetic way of walking alongside women with psychiatric issues in a few cases from the participants' narratives.

CHAPTER EIGHT

Getting Back to Work - The Role of Employment and Workplaces in the Women's Narratives of Psychiatric Illness

Our sense of belonging arises in marked degree from our relationships, and so many of our relationships are work related. Every day through our work our lives are given a structure, a purpose and a richness that we often ignore. (Bernard Marchant, 1990, p. 154)

8.1 Introduction

The Ministry of Health (2002) cites economic security and availability of opportunities as being crucial for good mental health. The world of work has the ability to bestow economic security and opportunity to the individual, as well as providing an additional sense of community outside the family and positive self esteem through accomplishments and a sense of social usefulness. It is the world of work for the participants in the present study that is the focus of this chapter. The chapter shows how it is clear, in terms of work, that participants have inscribed their own personal narratives with a sense of themselves as successful or unsuccessful as individuals, within the prevailing Western belief system that has been termed the 'Protestant work ethic' (Beder, 2000; Weber, 2002.) This 'ethic' has been deeply internalized by most of these women. Participants in this study on the whole showed a high level of optimism, endurance and success in their work lives, despite experiencing mental distress. Participants showed through their stories how work serves several positive functions in their lives. Mostly positive, but also some negative emotions, were expressed about the limits and accommodations that participants required to function vocationally.

8.2 The impact of the internalised 'Protestant work ethic'

The participants in the study clearly equated being able to work with being a productive member of society. One participant felt that she had an ordinary life prior to getting a 'mental illness' because she was in the workforce. Working was the norm to her:

I only got diagnosed about six years ago, with my mental illness, but before that I was living a sort of reasonable, you know, ordinary life. I was working. Well, I've worked all my life, basically ... It was really, I found it really weird because I went to – after I overdosed they put me into emergency respite and I (pauses) nobody worked. I said "I work" and people couldn't believe that I was working full-time and that I was at this place and I felt, all of a sudden, like I'd come – it was like it was foreign to me. I didn't understand why people didn't work. I've always worked, all my life. So I didn't actually have the understanding that – I just thought you had to work and that was it.

The participant quoted above was assisted through a government scheme to re-enter the workforce but felt guilty at the amount of money that this cost the government. Considering the cost, she felt that she was not really contributing in a productive way to the workforce:

It made me feel really – I actually felt maybe it was not worth working because it was costing the government more to keep me in work than it is actually to do the work. So, you know, part of me wanted just to give up work really ... but I think the thing is I really do need to work. I do need to do some work and I do need to have some – you know, feel like I've got something to offer. I think I would just totally – I think if I was just home all the time and didn't do any work – I think I'd reverse back into mental illness ... Mmn. You know, you've got to feel worthwhile and mental illness takes that away from you.

This participant clearly sees work as making her feel worthwhile because she can contribute to society and give something of herself to others through work. In another participant's case, being able to work equated to success and she made sure that she managed to hold herself together at work so that she could continue in her job. She also found her brother's inability to be successful at work difficult to understand, as well as not valuing some of his work choices:

I was still functioning on the outside – going to work, but just, you know, that really flat sense of – what I could do was put on a face for eight hours a day which fitted with when I was working ... My brother's older than me. He's 51. He's not a success at all unfortunately for him. He hasn't got a full-time job at the moment. Er, he's got a wife and two kids ... He trained as an electrician but he doesn't like doing that work. So he then became a salesman and set up franchise businesses but none of them were successful and now he's kind of fat and lazy and doesn't want to go back to being a sparkie [electrician] even though he could get a job. It's just – I don't understand him.

One participant had internalized a set notion of what a 'real career' is and what work is, valuing the former and not the latter, and for this reason viewed her vocational development at the time of her main period of unwellness as not being as successful as her friends. Her view of occupations was delineated between 'real careers' and shop jobs, with one valued more than the other, and this meant that she had a low sense of self-esteem despite being able to turn up for work and fulfil the requirements of her role. Work as a means to financial security does not figure in her account. She gives work extra meaning over and above. Work provides a sense of identity and achievement, a sense of meaning. Because she was unable to work at the level she wanted, this affected her career self-concept.

Well, when I started to get a bit better, X [names government vocational assistance organization] put me into a shop 'cause I had done retail until high-school – that was an after-school job. So they put me into a shop, sent me out and about (inaudible) working and I absolutely fucking hated it. It was like not getting anywhere or doing anything or – it wasn't a career – like, all my friends were doing their thing and, you know, people were achieving things and there was no way I was going to spend the rest of my life behind a shop counter.

Some participants had parents who had a strong work ethic, and this impacted them in that their self-esteem was tied in to working at a certain level and when they dropped below that level they suffered from low self-esteem, as these comments show:

Mum always worked ... I grew up in a family that was very kind of doing-orientated and there wasn't – we didn't talk about feelings and, you know, you just got on and did it and as long as you were getting 'A's on your report, you know, everything was kind of hunky-dory. So there were kind of expectations of achieving ... The first time, probably my worst depression, when I was in my early twenties, and it happened actually because I gave up a job and was without work and I was really surprised but the first day at home, having handed in my notice from this job, I actually fell into a big black hole.

Well, I knew with work – everything in my family was based around work. You had to have a job to be a decent human being ... I've worked from the age of ten, after-school jobs, and holiday jobs every holidays and, you know weekend jobs ... I worked my socks off. And that's been so hard to go to not working much at all. I've got my two and a half hour cleaning job a week and my volunteer job and it just seems so little compared to what I used to do. It's frustrating ... You're allowed to work up to fifteen hours I think without it affecting your benefit.

All of a sudden I wasn't working and I had worked all my life. I worked from the age of 15. I got my work ethic from my parents. It wouldn't have been tolerated for me not to work, and I always have worked. I've always had a job.

One of the first things one of the participants thought of was her need to explain her absence from work to her employer, even after a violent attack:

I was a very conscientious sort of person and one of the first things I thought when they had me at the hospital doing the routine tests was, I need to let my organisation know ... Obviously at that time I was in shock and there was all sorts of other stuff going on, but I knew that I had to let my workplace know. I've never been one to have sick days.

Even when this participant went back to work, she felt guilty when she was not able to complete her job to some of her managers' satisfaction:

I was devastated. I was devastated because I hadn't performed. I was partly sad because of the way they'd done it but most importantly to me was the fact that I'd really let people down, that I hadn't done my job properly. Yeah, for me that was like this 'oh my God, I can't believe it,' whereas previously it was always 'oh, yes, she's done such a good job and she's run the office by herself and she does this and she does that.'

This kind of shock about not being able to function at a previous level is evident also in the following participant's comments:

It was like ugh, shit, and that's the whole, um, kind of, expectation thing – the Virgo, the perfectionist, the teacher, you know. I should be able to be okay at this, you know. I suppose for me, up until I was pregnant, actually, up until I gave birth, everything in my work-life had been sweet, um, quite a confident worker, very fastidious, a bit of a perfectionist, um, had a baby and don't know quite what happened but, um, things started to (pauses) go downhill. I was absolutely petrified of being in a room with a group of people and up until this experience that had been my forte.

For those participants who were not able to work to their previous capacity, there was a real struggle to cope with a life without full employment. As one participant put it: God worked for six days and rested for one, but she was not able to follow this code:

God rested on the seventh day. I work one day and rest for six (laughs.) God worked six days and rested for one and I work one day and rest for six (laughs.)

Another participant found ten hours of work a week hard to cope with and this dented her confidence.

I only worked ten hours but it takes hugely more energy than that. You don't ever kind of let it go.

Another participant felt that there was a shame attached to being on a sickness benefit. She could cope with the idea of being on the domestic purposes benefit more easily than the

sickness benefit. For her, the status of a single mother was easier to reconcile with than the status of a person too ill to work, as this comment shows:

I'm also quite a sort of proud, you know, get it done, dig-in kind of person ... I've had to go back on a benefit which I really didn't want to. They said to me, look you can go on sickness benefit or back on domestic purposes. I'm glad I chose domestic purposes because I was filling out a form to do with money the other day and it has all the questions about 'are you on sickness benefit and blah blah blah?' and I thought 'ugh' (laughs.) Stigma. I sort of feel, like, even though there's stigma with any benefit, I felt I can live with being a sole parent.

She felt much higher self-esteem when she managed to go back to work but then found that she needed to go on a benefit again. She found this hard to accept despite the positive support of social welfare service staff:

They were really supportive at WINZ [Work & Income New Zealand]. I felt a certain shame. I had felt really proud of being able to get off the benefit, you know, and I kind of felt "Oh, oh, I didn't succeed at that".

Rather than going on a benefit, one participant mortgaged her house to cope while unable to work due to psychiatric unwellness:

Well, I didn't expect to be around for very long, for two years ... for two years I lived on my savings (long pause). Well, I mortgaged my house. I had a mortgage-free house and I actually mortgaged my house to live ... I don't want – well, I'm not comfortable being a beneficiary. I don't think it's – well, I don't think it's – you know, it's much better to be self-supporting. I mean, who wants to be a beneficiary? (laughs).

Another of the participants would not consider Accident Compensation Corporation (ACC) payments to help her cope with the trauma of her attack and her difficulties with work:

I doubt very much that you'd want to go with ACC for a rape complaint. It's hard enough to get counselling money, let alone to get them to – . And the other thing for me was that that wasn't where I was at. It wasn't in my make-up to think – (pauses.)

During the late 1990s and the early years of the new millennium in Aotearoa/New Zealand, there was a significant social welfare push to get people off long term benefits (McGurk, 2008). This, combined with the stigma of being on a psychiatric illness-based benefit, led some participants to seek out alternative means of support for themselves while they could not hold down a job. Some participants went back to full-time study because they could not work. They were able to access a student allowance rather than the sickness benefit or the invalid's benefit. Some used full-time study as a way to feel they were still functioning in society and maintain self-esteem, despite not feeling able to work, as these comments show:

I was only fit just to be a student, just get backwards and forwards ... It's a good story. A story of how I struggled to get there but really about the value of the education. I just loved it. I fell in love with it.

It was a creative course I was doing and I was really looking forward to it 'cause I had every – you know, half the week the kids weren't with me. So it was like trying to fill a gap as well. Really, really loved the course and all that but the year after I left that was when I went down again.

For another participant it was a purely fiscal decision as the following comment shows:

I didn't really know what to do and I ended up doing some really stupid courses as a way of surviving. I had some student allowance left to me. I had two year's worth and I kind of used that as a safety net, a way of surviving. The student allowance became my kind of income and I did, for one year when I was particularly bad, I did a correspondence course with the Open Polytechnic. I wasn't really able to go out of the house much.

Undertaking study was approached seriously by these women, even though it would not have been their first choice. They invested a lot in it in terms of trying to maintain their self-esteem and avoid being on a sickness or invalid's benefit. The one participant in the study who is school-aged found it hard to miss out on schooling due to her psychiatric unwellness. For children and young people, school could be said to equate to work as a compulsory activity most individuals are meant to undertake as citizens (Ramirez & Boli, 1994.) This participant felt a sense of loss at missing school:

I missed basically a whole year of schooling, yeah, and then, last year and the year before, I often had lots of time off school. 'Cause I just couldn't handle going to school. So I just wouldn't go. And I'd go to school and I'd just feel miserable. Like, it really hits your concentration. Like, you just don't want to think about anything and like it's sometimes, like, just go to school and go just stop thinking about it and just concentrate on the work but it's like so much easier said than done to do that. So yeah, it did interfere, you know.

8.3 The responses of employers and work colleagues to participants' psychiatric illness

Participants have worked in a variety of different workspaces from social welfare organisations and public health organisations to universities, schools, shops, light industry, and their own premises as self-employed women. For the most part, the women were initially met with care and concern from their workplaces, as is evidenced by the following comments:

Work was fantastic, the organisation that I worked for. I think the credit goes to the organisation just in terms of their support when I became unwell, because they gave me as much time as I wanted off although I only took a week.

Work were fine. You know, it's just 'How are you doing? What do you need? Do you need us to sort out some more leave for you?' It felt safe. Yeah, it was great.

We had the Monday off work 'cause we'd been over to X [names city on other side of the North Island to where she lives] and I was becoming manic over that weekend and, by the time we got back, poor old X [names current partner] didn't know what was happening. His daughter picked it up and she rung the ambulance (pauses.) So X [names current partner] rang them the next day to say 'look, X's [names herself] not at work because she's in the wars, she's – .' Um, I don't know what he said. But the next minute a big huge bunch of flowers arrived and the second day – and I was still in X [names psychiatric inpatient service], the receptionist [from her workplace] comes waltzing on in. 'What the hell are you doing in here? Get back to work. We need you. You're supposed to be doing our pay' (laughs.)

I was immediately given the message that – to take as much care of myself as I could and they would be in touch with me, etcetera. I had (pauses) – my workplace sent me simply gorgeous flowers. X [names previous manager] who was the person in X [names North Island city] who I'd contacted, she was the person that contacted me and they decided as a workplace it would be good if it was just her that contacted me which worked really well. It meant I didn't have to talk to lots of people. She came and saw me (pauses) a week after [the rape] happened, which was lovely. It was really nice that she actually came to see me and she told me then that, you know, they had talked about what had happened to me and that the staff had been told and she hoped that was all right, but, because it was such a big thing, they felt that people needed to know because, obviously, otherwise it was going to become a gossip kind of a thing and they didn't want that ... And she also said to me that they'd talked about what time off I might need and that they were very happy to accommodate whatever I needed. I felt a huge amount of support about having time off, although I was actually in no fit state to go anywhere (pauses) and I had (pauses) – I think – I'm actually unclear about the exact timeframes – the whole area – kind of – my memory's not so good around it. But I had at least two full weeks off and possibly three ... And so they said to me that if I wanted to come back on a part-time basis or whatever – so that was good. So anyway this woman said to me "look, um, I'm really sorry about what's happened and we really want to find ways – ." You know, I'd been there for three years at that stage. "We really want you to stay here and we really want to support you and find out what things we can do to support you and make you safe" and all the rest. And so that's when we talked about things like whether or not we needed to have a buzzer so I could – like, when other people weren't there. Do I want a panic button? Do I want a mobile phone? Now this is ten years ago; mobile phones were not common in those days. But they were prepared to supply me with a mobile phone, not just for work but for home and also to put an alarm into my house. I said I didn't want a mobile phone – a waste of time. But I said I would like an alarm in my house and they did put an alarm into my house.

As time went on, workplaces continued largely to be sensitive to their employees' needs.

One participant's manager found someone else to undertake her work and then, when she was able to return to work, came along to the workshops she delivered once she returned to work, in order to support her.

They were very, very supportive and in the really intense period I – the workshops that I had to run were – , um, (pauses) someone else took over and then as I gradually started to (pauses) feel a bit more confident I would have the support of my manager who would come along as well.

Another participant's workplace went to great lengths to help her both professionally and personally during a power crisis in her city:

Now one of the things that happened around that time was it was when the power crisis was ... I worked in an office in X Road [names city centre road in upper North Island city] and we shared the offices with quite a big NGO [non-government organization] and they decided to decamp because, of course, they had a contingency plan. So they moved them out to X [names suburb of upper North Island city] or something, and said 'we're not going to be here' for I think it was eight weeks. And so [my work] couldn't leave me my own – well, for a start 'cause there was no power for the first two or three weeks, but they couldn't also leave me in the office. I wouldn't have wanted to stay under any circumstances but particularly given my own circumstances – the fact that my manager was away a lot. They said to me 'You need to work from home.' So we diverted the phones to my home ... I know we were talking recently at work about what we would do if there was a flu epidemic and were saying, well, people could work from home.

Not all of this participant's experiences would be positive despite this good beginning. The way in which the organisation gave her one key person to liaise with, a woman, was hugely beneficial. Also, the measures they put in place to support her during the power crisis were admirable. However, as time went on and she was unable to return to her previous level of efficiency, other people in the management team began to feel the need to take her to task for what they saw as her poor work output. This was counterproductive to her recovery due to the very formal and non-transparent way in which they dealt with the issue:

It was very difficult and the other thing was that one of my major symptoms of my post-traumatic stress was that I jumped every time the phone rang (pauses) and I had the job of answering the phone. The phone didn't ring a lot but it rang enough that every time it rang it unbalanced me, basically ... I wasn't working to capacity. I really lived in my own little world in those first few months when I actually didn't realise the impact that it was having, the wider impact that it was having, until my manager said to me that the chief executive was coming up to meet with me. Now I'd had a very good relationship with the chief executive prior to that and I didn't really think too much of it and, so, he came up to the office. They took me into the boardroom. I sat on one side of the table and two large men sat on the other side of the table and they said "now, we know that you've had a really difficult time but we need to talk to you about some aspects of your performance." I was stunned. Not so much that they wanted to talk to me about aspects of my performance, but about the fact that they'd given me no warning that this was going to happen, that my manager hadn't talked to me about it in a different way. To me it felt like it was a full reprimand. I semi-managed to keep myself together during the time that they talked to me. I can't remember what they actually talked to me about, thinking about it now I'm thinking, 'what the fuck did we talk about?' One thing was that I hadn't done the

manager's filing which he'd never talked to me about. I just remember sitting at this table feeling totally overpowered by these two men and not sure what I could do. The other thing for me was that I was a single parent with two children and no support from my husband. So having an income was very important to me. I'd just moved into a house so, you know, I had a huge mortgage and financial – ... I don't think there was malice in what those men did when they came to see me about my performance at all. I think it was just that they hadn't considered it. They hadn't talked to any women about the conversation, whether it would be a good idea or not.

What this seems to show is that, according to my participants, key people who understand and are supportive are crucial and that there is a window of opportunity in some cases in which someone in mental distress can be given accommodations and supports before the usual work output is expected again. Also, one person – a kind of mentor even – who takes on the 'project' of supporting the worker with a psychiatric illness is hugely beneficial to some people. The response of management is crucial. In the case of the participant quoted above, a manager of the same gender was very important. Also, accommodations and workplace supports such as the panic button in the office and an opportunity to work flexibly, sometimes from home, were beneficial.

Other participants in the study actually had good ongoing experiences from the workplace after an initially positive reaction from their workplaces. Two participants had been sent flowers, given time off and been visited by a female employee of her organisation and this positive approach from their workplaces continued. One workplace seemed to be unfazed by their employee's hospitalisation and her diagnosis of bipolar disorder, as a participant explains below:

They were good, yeah. My boss – like X [names current partner] had taken me in for a coffee and stuff every now and then, just so I was keeping in touch, and I'd ring them up 'cause they only give you a certificate for six weeks. So every fourth week I had to go in and see X [names boss] and say "I'm still not well enough and da-da-da," and I said once "if you want to get somebody else in my job, I'll understand," and he said "until you tell me you're not coming back, this job is yours."

Another participant, who is a teacher, had good experiences with a workplace that was supportive and made accommodations beyond those she would have expected, as her comments show here:

Luckily my school was very supportive and my board chairman was a psychologist and so was his wife. So they got me onto a colleague that they felt would be suitable

and I saw her by that Friday and I just cried my way through that first hour and she identified issues even going right back to my birth ... childhood issues that had led on to relationship issues as an adult and she said at the end of that hour that she felt that I had a quite serious clinical depression. X [names her workplace] were really good because they gave me as much paid leave as I had left and then I had unpaid leave and the board met with me to (inaudible) they were very accommodating and they offered to do what they could and so I decided to job-share and – primary schools (inaudible) four years ago it was still fairly uncharted territory and a lot of extra people work in there. A lot of schools would have just said (inaudible) but they were great and put that through. I was allowed to pick who my job-share partner was so I offered it to a friend that I could work in with and kept that going for – I returned in July, two months after it initially happened, and they were great. I mean my DP [deputy principal] would come in every day and just check I was managing and my principal touched base once a week, one-on-one time and at the end of that year they offered, I now regret that I didn't do it, but they offered to do whatever they could to make it work for me. They said you can either come back fulltime which none of us thought was a good idea. I could make that job-share permanent which, although they weren't overly happy with my job-share, they offered to do or I could take a year's leave of absence. So I chose the year's leave of absence because I still felt - and at that stage I was still on my pills. I still felt quite grey most days, quite weary and so I took the year's leave of absence and did some part-time work at other schools and some relieving during that year, at that school too, but by the end of that following year I still felt not well enough to go back. I probably should – they still offered me the job-share as a permanent option but it just felt too much and I just felt 'ugh, do I?' and I didn't even really know if I wanted to do that. So I guess I've got this deep sense of ethical honour and I sort of felt like I'd kicked them around quite a bit and by then it was nearly two years down the track and so I handed in my resignation. Initially they didn't accept it and gave it back to me but then I just – so I resigned totally and I still have some connection with that school with relieving. I don't know, in hindsight, if they would take me again now but then I don't know if I would want to go back. But if I did, I think because it was such a drawn-out process and it was fairly unstable and I guess they get over 180 applicants per job, I don't think they would risk that again because certainly in that situation I would have felt the way they handled it, they went way beyond – I mean, I was the union leader at that school and they went way beyond what we had recommended.

Other participants had positive workplace stories, though none as outstanding in terms of support and flexibility as those related above. One participant found her manager to be especially helpful in showing her how to set limits and boundaries so that she could protect her mental health:

Okay, now, X [names manager] walks the talk, okay? She has no personal experience with depression herself. However, she, um, is – has a nursing background. And she's just – I've just found her really supportive; none of this kind of 'I'm the boss' – and, you know, she says 'yes' whenever possible and she's made my life there really easy. Always supports me if I want to go on a course or something like that, and she'll, you know, do whatever she can to find the money for me. Always happy to answer any questions I've got, no matter how many times I've asked them before (laughs.) You know, just really patient, really supportive. X [names manager] is really good at setting boundaries and I've always – she's worked with me and taught me about that: "no, you can't - you don't have your phone on when you're not

at work and you're not available and people have to understand that." So that was quite a whole new thing for me.

For the participant quoted above, her manager has become such a cornerstone of her wellness at work that she has decided to leave her job because her manager is also leaving. While her manager was away she found that she was becoming unwell. This shows that the key managerial individual is essential for some employees' continued wellness at work. This can, of course, put a lot of pressure on that individual to maintain working conditions and offer ongoing support to an employee with a psychiatric illness. It also leaves the employee vulnerable if that individual leaves the workplace:

She's leaving too. That's actually one of the reasons I'm leaving ... - last year she went over to X [names country overseas] for a month and that was when I got unwell.

Negative stories of employers were surprisingly few. One participant, whose managers have been aware of her 'mental illness' for sometime, is aware that her colleagues can be angry about the accommodations she gets from her employer, because her colleagues are not aware of her 'mental illness.' She is grateful that management has been supportive of her during illness phases that have included suicide attempts:

They're very good to me. They're very, um - they accept it. They know that I've overdosed a few times and I've been in hospital and haven't been able to go to work. So they know that, but they still let me do the medication and I'm still in charge of all their pills ... and they let me have the responsibility back. They said to me, though, that if I ever did use the pills that would be the end of me and so I never have. I've never touched their pills. Yeah, they seem to cope. Sometimes they get a bit mixed up where they put a bit of pressure on me to keep working and they don't quite understand that I can't cope with that. So often they forget that I've got a mental illness, which is good 'cause they just treat me like everyone else in the workplace. So I've got to say "this is too much." It's me that's got to do that ... At the moment they're going on a camp next week for seven days and you're meant to go in your contract. You have to go to it, but, like, every time I've gone to it, I've come home and overdosed. So I went to my doctor and got a letter to say that I couldn't go to the camp. The co-ordinator said that was fine but the other staff don't understand and don't know and so they're all very angry with me that I've got off.

What these narratives seem to show is a positive approach from employers to their staff experiencing psychiatric illness, especially at the outset of the illness. This appears to provide a window of opportunity that needs to be maximised. Fellow staff may not be so tolerant over the long term, particularly if they are not fully informed. Nevertheless, it shows that workplaces, and particularly management, seem to be developing an emancipatory

'literacy' around psychiatric issues in the workplace and that this approach is productive. It must be noted, however, that these positive stories come largely out of the health promotion and health service provision sectors and the education sector. They may not be representative of every sector of industry in Aotearoa/New Zealand.

8.4 The functions of work for women experiencing psychiatric illness

For one participant, on a day when she was suicidal, it was the fact that she had a workplace that seemed to provide her with a safety net. Despite knowing that she could not continue in her job long-term, in that moment of deep anxiety, she knew to stay in her workplace that day and not leave it or she might not get through her suicidal phase. Being around other people and having their company provided solace. This social and supportive function of work (when an individual experiences positive social regard and assistance from others) is not to be under-estimated, as her comments demonstrate:

I recognized - the boss had come out after a while and she said "oh, look, you know, if you're not well, look you can go and I'll work your shift." And I said "no, no, no" because I knew at that point it was kind of dangerous. I had a sense that if I left work at that moment - , I had a sense that there was nothing to go to and I might have just (pauses) done something ... At that moment there was a sense of knowing that I couldn't stay in this job - but at that moment I knew that if I walked out that door I was going to stand in the middle of the busy road. I mean that sounds dramatic but I just knew there was nothing outside of there, you know. I just had to stay.

Another participant, after being raped and suffering from post traumatic stress disorder, also appreciated the social buffer that work provided:

I didn't want to stay at home. I couldn't be by myself at that time. So - and I was running out of people to call on to be with me and, I thought, you know, it's time to go back to work.

The following participant's comment shows that, despite only earning a token wage, she also found work through a rehabilitation scheme socially important:

I've worked at X [names a supported employment organization] which is part of 'X' [names the psychiatric inpatient service she was admitted to] and I was working in the kitchen out there and I was in the horticulture. You get paid a community wage which is like \$2.50 an hour or something ... The money is crap but it was good to get out and do something. It made me feel worthwhile and I had somewhere to go and someone to talk to.

Working as a consumer advisor in a non-government mental health community organisation provided one participant with a sense of social support at work for the first time in her working life:

Well, I actually never really acknowledged the effect that mental illness had had on my life until I started at X [names government funded public health project with a focus on mental illness.] And it was only when I was working in an environment where it was really supportive that I started to think “gosh, now I know why I’ve had trouble in my working life”.

Other participants also felt the positive social function of work for them and felt that they had something to contribute to others:

I want to be an X [names recreational officer type position] at X [names a mental health community-based rehabilitation service.] I’m a member of a few groups there on a couple of days and I’m a volunteer worker there ... I like the people and I like all the activities and getting involved and encouraging them and supporting them.

What I really enjoy about my X work [names government funded public health project with a focus on mental illness] is that I feel like I do inspire other people and I get a huge amount of satisfaction out of that.

While her workplace was not aware of her ‘mental illness,’ another participant nevertheless found it supportive of the way she liked to work, with a lot of flexibility. She was working in the health and disability sector and the workplace seemed to have good practices in place for both their workers and the clients they served. She appreciated the sense of self-efficacy, success and achievement that came from being able to perform well in her role:

I guess you would say the management and these people that I’d worked for before had been kind of like a buffer. They had a really nice manner of working with people and they’d buffered me I had a really nice boss and I found the work really do-able. Part of what was good was that they were really nice people.

Another participant also expressed a sense of self-efficacy and the positive feelings that performing well in a job evokes in them:

I’m an organized person. So being organized when all the rushes came was a bit of a high, a bit of a buzz to get through everybody to get them served. [Work] makes me feel competent, confident, fulfilled and generous.

For another participant, some workplace challenges were easier to cope with after her ‘mental illness.’ This gave her a stronger sense of confidence and self-efficacy in her work:

Like I used to become very, like, when I was younger, when I first started, if somebody challenged something that I’d said, or asked me a question that I didn’t know, well that would be - for days I’d be like ‘oh, I didn’t know that question or they challenged me.’ Whereas now I think if I don’t know the answer, I’ll just tell

somebody. If they challenge me I'm confident enough to say 'Well this is the belief that I hold' or whatever, however way I deal with it.

Another participant also showed a strong sense of self-efficacy. She felt that dealing with her phobias in her life had strengthened her and enabled her to take on leadership roles as these comments show:

In certain ways, in terms of the need to take responsibility and leadership, [my phobias] actually enhanced me as a person and probably enhanced my career as well.

One participant is so certain that mental health services are vital for recovery from a 'mental illness' that this has led her to want to train as a psychiatric nurse. She has a profound sense of vocation about her new career path. She feels she has knowledge to impart to reorient services and make them more positive about outcomes for the people with psychiatric problems, as her comment below indicates:

I want to go and do my nursing training and I want to be a psychiatric nurse. You know I'm passionate about people getting services and treatment that they need and I'm passionate about not writing people off. You know, sometimes they say 'oh, she's always going to be in residential care' or 'she's level three' or this, that and the next thing, but I don't believe in that. I don't believe that at all. I just believe that the key hasn't been found for that person yet.

It is her belief that people with experience of 'mental illness' make especially useful staff in mental health services, while she also acknowledges the challenging nature of the role for psychiatric staff:

People, like nurses and people like that, those who have experience of mental illness themselves tend to work better than others. But I think at the end of the day, it's a bloody difficult job to do and anybody that takes up that challenge, you know, gets my clap, honestly.

Two participants had been able to work in creative occupations through which they felt work provided a nourishing function that helped their psychiatric illness, as these comments show:

The creative part of me's really big, and if I don't fulfil that I get unwell. So I've been lucky. I've mainly had creative jobs which have nourished my soul, if you like, and I can keep my mental health well ... So my creativity's really tied up with my mental well-being as well.

Once I released the album I did some touring ... and now I'm actually feeling like I've got the flow back on which is just amazing because, you know, when you write and when you feel you're writing well and feel what you're writing has value, it just spurs you to write more.

8.5 Integrating psychiatric illness into worklife – accommodations and limitations

Many participants who were high-fliers have down-scaled the work that they do or chosen not to carry on to management careers. Some participants seem to have learned what their limits are and have a confidence in expressing this. As this comment shows, knowing their limits is a good thing for them, rather than a topic that brings up feelings of loss, as it did for those participants cited earlier in '7.3 Identity loss, discrimination and stigma – Negative social experiences of being 'mentally ill.'

I know exactly what my limits are and if I reach my limits I says 'well, sorry - that's beyond my limits' or 'if you want me to go to X [names a South Island town], would you accompany me on that trip?' So I know how to ask for what I want. I mean I really cope very well. So I think that's probably it.

Some participants have chosen to down-size their careers, not seeking such high-pressured and prestigious roles as formerly, as the following comments show:

My first goal is to get a job that's not quite so high-powered because I think that would reduce quite a lot of the stress and pressure in my life.

Although I love having a career and I do like working and I still being in the workforce, I, you know – I do want to do my job well but I don't want to have that extra responsibility that makes me have to be away from home for a bit longer, or makes me really stressed out about who's getting on with who and why that person didn't turn up, you know, all that stuff. There's more important things at this time in my life.

Down-sizing a career might not be as rewarding or unstressful as expected due to unforeseen variables. The following participant's story sounds a cautionary note:

And so working in a fabric shop was my dream. I liked working with the fabrics and I was fine with the customers and I'm not very good at maths but I did everything really methodically on the calculator and I never got anything wrong. But unfortunately the man who ran it, he was constantly monitoring and watching me and he didn't like that I did everything on the calculator. He thought that must mean that I was really thick and useless and he got worse and worse in his behaviour towards me.

It may be that down-sizing involves not so much an industry shift as a reorientation to the same industry based on getting specific accommodations. Flexibility in terms of the hours that one work starts and finishes and an ability to work according to one's wellness levels, appears to be a much sought after and useful workplace accommodation, as the following comments show:

And tied up with that is a - is an inability, if you like, to go and work in the normal kind of nine-to-five routine. I need to be flexible with my energy flows, with my ups and downs. I hate having to be at work at, you know, nine o'clock in the morning. I work better if I've got a bit of flexibility. I like to work alone and I like to be my own boss as

much as possible. And those are the kind of situations that work best for me. And I don't know whether they're personality things or whether they go with the mental health. I do know other people with mental health problems that have similar kinds of things ... We did a couple of all-nighters finishing wedding gowns and I just couldn't handle that stress 'cause stress is a big trigger for me ... time pressure is not good for me. And it's interesting - this kind of illustrates how I am. In the dress-making business, people would come to us and we would make a garment for them. Now I found that really stressful and yet I really love making garments and, if I can make a garment and put it on a hanger and somebody buys it, there's no stress involved in that ... and I really - like people have said to me, "do you do commissions or can you make me a ball dress?" and I just go "no, I can't. I won't" (laughs.) I mean that's the difference for me. That's why I like to sell my scarves on commission, because it's like, if they don't get sold, that's cool; they can come back to me. And none ever have done, but it - for me, it's just a whole different pressure thing. I haven't quite figured that one out. I just know that it works.

And the thing with relief work is, if I get rung in the morning and if I've had a bad sleep or if I've had a bad few days, I can say "no, I'm not available."

Being supported and being flexible with my hours and all of that. And X [names government funded public health project with a focus on psychiatric illness] has been hugely, um, supportive of that.

These comments on down-sizing and flexibility speak of personal agency existing in the face of mental distresses and a clear understanding of the ways in which mental distress can conflict with career concerns. Despite the identity loss or unforeseen problems that accompany some of the participants' decisions, career development becomes aligned to psychiatric treatment as the participants attempt to negotiate a vocational identity that can co-exist with psychiatric illness. Autonomy was also useful for participants even when work hours were not flexible, as this comment shows:

I loved [shop assistant work] at the time. It was sole charge and when it wasn't sole charge my boss was asleep in the back. Oh, it was cruisy. He's an alcoholic - so he'd just go to sleep, cigarettes burning and you know ... I had time to myself and it was really, um ... And I could run the whole place by myself which was really cool.

Another participant discovered that a job with flexibility and a lot of autonomy suited her. She surprised herself by being able to do the work she found through Student Job Search when studying for a postgraduate degree as a mature student, as these comments show:

I looked at Student Job Search, had a job up as a job coach and for some reason I applied for that. God knows why I did because I had no confidence that I was capable of doing anything by that stage but for some reason that worked out really well. They pretty much left me to do my own thing and I was sort of my own boss in the area that I was working in. I had a really good relationship with them and, if I didn't want to do a job, that was fine with them and it was a lot of give and take. That

continued very happily for almost a year and then sadly that company had to fold for financial reasons.

One participant describes preferring work roles that have a strict locus of operation and boundaries but plenty of autonomy. She used to work on discreet, specific projects with a defined beginning and end, and uses the term 'fit' to describe such successful work scenarios in her career:

Well, I've been a teacher and I've been a community development worker and a health promoter and, um, a tutor in an educational kind of programme for kids that have left school. So while they were intense jobs they, they were jobs that you did in a kind of particular confined kind of space, I suppose. And they were programmes of their own right and I could easily get away with no one ever knowing that I had experienced depression or that I - , um, and I don't feel that I felt the impact as much. I think I felt a bit more in control. I knew what I was doing. I think that it's kind of like it's about where you fit, and I think that, if you're not feeling like you're fitting, then that definitely impacts your mental health, yeah, for sure. I realise, in the job that I'm doing now, is that I'm not using the skills that I know that I - I'm using skills that I've got, but I'm not using the skills that are my best, if you know what I mean, and they're my people skills and building relationships and all that kind of stuff, which is what you have to do when you're teaching or tutoring or whatever. I mean that's so much a part of it.

Another participant also did not cope with work that was not circumscribed with an end point in sight:

And that sense of never getting through your work. It's like my in-box is always just over-flowing and I hardly ever get to it and I don't like that, that's stressful for me.

All of the women quoted in this section are clear that work is a central part of life and feel that they should be undertaking it. There is only one participant in the study who voiced some of the situations in which work is not essential for a woman. One of the oldest participants in the study, she tied this clearly to having a man to provide for her, rather than critically deconstructing 'work' as an essential component of modern life, as these comments show:

You know, if you've got a partner that necessitated you to work, you'd work. If you had one that you didn't, I wouldn't. I've had partners where I wouldn't have had to work. You know, really well-off ones and so I wouldn't - you know, if I didn't have to, I wouldn't (laughs.) Some men are full-time jobs and I've gone out with men like that, like multi-millionaires. I don't have a need, um, because I can always find other things to do. I would, you know, if I had found a person, I would have then put the energy into, um, children or, you know, supporting the partner or whatever. So, no, I don't have to work. It just depends on what situation you're in.

What is clear about these narratives is that they are spoken by women who have come through a period of psychiatric illness to a place of acceptance of themselves and their needs. This awareness of their needs and the ability to operate from a position of strength has been earned after a period of debilitation. As she got older and learned more about her psychiatric illness, one participant was able to identify what she needed to get through, as this account of her time in parliament shows:

So then I got elected to parliament and I had agoraphobia there as well - only about where I was going to live. And I resolved that by living in a hotel that had a 24 hour desk and I got a room on the floor dead above the reception desk and I stayed there in that room, two nights a week. But I always went back to that same room for six years.

The participant quoted above took a practical approach to some of the psychiatric issues that needed to be resolved so that she could work as a Member of Parliament (MP.) This shows the type of problem-solving approach that would be valued in her role. Despite needing accommodations that she arranged for herself, she was nevertheless very 'out' about her illness and male MPs learned quickly not to be patronizing to her about it.

I remember X [names a Member of Parliament] once was going on about "you must be mad, you must be mad blah, blah, blah." Really disrespectful stuff. And I went up to him and I said "X, you are a leader in this society. Can't you actually have some decent attitudes towards people with mental illness? Don't you understand that when you say that stuff?" And you know, he was pissed off with me for saying that but I noticed that his behaviour in that respect improved.

Work is important to all of the women in the study. Some feel that they have achieved their work aspirations and others do not. Mental health professionals or workplace mentors have helped some participants to have and achieve career aspirations. This reliance on the mental health sector and on empathetic workplace mentors may well be a different platform for achieving dream careers for the women in the study compared to other women in society. Certainly, a graduated approach to achieving a dream career worked (one that would presumably work well for women without 'mental illness' too), as these comments show:

I said "I want to be a vet nurse," because I always have, and I thought to myself, 'well, I could have a job doing something I love and might actually stay well.' So I went to one of the vet clinics and put my name down for some work experience because X [names contracting business] got really quiet so they cut my hours from full to part-time. So while I was doing that I was at X Vet Clinic [names clinic], they were called, doing voluntary work. And, when a job came up, the boss said "I'll give

you an interview.” So I put my CV in and da-de-da-de-da. I said “okay then - I’ll give it a go” and I worked weekends from ten to four every weekend ... and then what happened from there was, well, I quit my job anyway at X [names contracting business] but within about two or three months the girl - there was three vet clinics, you see - and the girl at one of the vet clinics left and she just so happened to do the vet clinic’s books. So I said “um, I can do that” and X [names vet] said “fine, you’re employed” and I ended up working - it was more than a 40 hour week, eh. It was like from nine to seven ... I started my vet nursing training which you do mostly through correspondence and you have three sessions in Wellington and that was two years and that was the first time I’d ever completed a qualification. I was just absolutely rapt. It was really funny because at the time I was already separated from X [names ex-partner] and I banged into him in town and he was always calling me a quitter ‘cause I start things, get unwell and not continue. I finished it and I ended up - I banged into him in town. I said “oh, I finished my nursing qualification by the way” and he just sort of looked at me, and I said “you didn’t think I would do it did you?” (Laughs.) So it was really exciting ‘cause I didn’t finish my teaching degree, I didn’t finish my hairdressing qualification. I started, while I was at the X Club [names the club] - I started some psychology papers. I was going to be a counsellor. I didn’t finish that. I started some accounting papers - didn’t finish that qualification (laughs.) So I’ve got bits of everything but not much of much. I was just really excited to finish a qualification because that meant I was like my brother and I was like my sister and I was like them. I wasn’t a failure.

Severe depression, anxiety and phobias in my early 20s led me to a counsellor. One of his suggestions was to go to the lovely X University, just over the river. I laughed at him. Not only was I a school drop-out, but my phobias were so bad that I could never manage to get over the bridge. But, you know, the idea took root. Over a period of a decade I went from a housebound person, lacking self-confidence, ignorant of the ways of the world, depressed and with few plans for the future to a graduate, BA, MA, PhD, a lecturer, confident, engaged, excited by learning and knowledge and with a wonderful career ... then spent six years as a Member of Parliament.

She was a real mentor to me. She was really, really supportive of me. We had a great relationship. We worked really well together and I really grew under her leadership ... I did management training while I was there. When I talked to her about what my own career aspirations were - when I went there I guess I didn’t really have any major career aspirations as such. I was still bringing up my children and that was pretty much what was important to me, plus recovering from what had happened to me. So I hadn’t given a great deal of thought to my career, but I think that X [names chief executive of mental health organisation] made me probably think about that differently.

It is clear from these accounts that some women have felt very fulfilled in parts of their working life. They have felt successful, with the support of others and after a difficult start back into the working world due to their ‘mental illness.’ This is not the case for all of the women in the study, however. One participant felt the loss of giving up early career aspirations as these comments about nursing show:

So I’ve got the dyslexia and the mental health and they’re both really - yeah, my dream when I was a child was I always wanted to go nursing. I definitely had that

dream and I used to carry a box of all these nursing bits and pieces - bandages and that – and I'd be the nurse in the area, you know. That was always what I wanted to do but that couldn't really happen.

Another participant noted that she would not like the stresses of a management career and eschews the linear progression to management in her career. She is aware that she may well not be able to achieve her dream career in a different field, due to her psychiatric condition:

My dream has always been to work in schools as a facilitator because I like young people. I've done quite a bit of work with them and I don't know, I just, I like the whole group thing but it's really tiring and there's a lot of planning and effort that goes into it.

For one participant, having given up her career dream of being a teacher many years before, her aspiration at this point of her life is not so much about progressing in her work roles up a ladder, but expanding her capacity to being able to work more than a couple of days a week. This is so important to her that she entered an experimental drug trial in the hope that this would make her better able to work. However, the aspiration of being able to work more days in the week due to help from a new medication has not been achieved:

Obviously mental illness is absolutely dramatic. You know, I wouldn't - I would have - if I had chosen, I would have continued and been a really successful teacher. That would have been my choice. That would have been my choice ... The reason I'm doing this drug trial thing is just because my capacity's been impaired by the, because I drove myself for so much of that time I was really depressed that it did damage to my brain which burned me out. And this drug - if I'd been - I actually got the placebo but if - (laughs) as 50 per cent of the people do, but if I'd actually got the real thing, the people that had the real thing blossomed, absolutely blossomed because it gives your brain a rest and allows your brain to heal. Just a week's rest and they've become - their concentration, their memory and everything, a bit more energy which is what I wanted because I wanted to become more productive than a day and a half a week.

Even the school-aged participant in the study has learned to curb some of her aspirations due to her 'mental illness' and, like the woman quoted above (one of the older women in the study), has trouble working a full week:

Well, when I was little I always wanted to be a X [names a kind of dancer] and I did X [names a kind of dance] and for like 12 years or something - so I did do it for quite a long time ... Like, I thought maybe I could be a X [names a kind of dance] teacher but I did, like, a trial of that last year. I taught a couple of little kids' classes a couple of times a week last year and it wasn't as good as I'd thought. It was quite fun, but it was such hard work and I was, like, I couldn't do this every day for hours. It's too hard. I just found it exhausting and that was only like two days a week or something. So I decided "no."

Most women in the study joked about ideal careers if they brought the subject up, rather than exploring the idea fully. Several participants had the idea that their dream or fantasy of running a café would mean a downsizing of the stresses in their life. Their café dreams were not that serious, however, as the following comments show:

I think there's still the fantasy of opening a coffee shop, but, hey, you know, that can be a fantasy (laughs) ... there's always the fantasy of winning the lottery! (Laughs.)

I always used to say "oh, I'd like to just go and work in a nice little café" and it's kind of like this little pipe dream that people have when they're in a stressful job and they think "oh, I'd just like to go and do a nice little simple job. It would be so pleasant and easy."

I love the intellectual side of my job but I'd love to run, like, a café, you know, a bit of a bookstore here and a few nik-naks that you could sell and people walk in and go 'that's the owner' and say 'a flat white, thanks' and be the owner. That's a wee fantasy.

One of the younger women in the study had only recently considered what she might like to do most in life. Like the café idea of some other participants, she had an idealised view of her dream profession:

I mean, up until the last year or two is the only time I've ever thought of what kind of job I'd like to do; what do I want to do with my entire life? 'Cause everything was just around Mum and working ... Working in X [names a town known in New Zealand for shipping and sailing] on a boat being a skipper ... up above with all the scenic views and the boats and the fresh air and the sunshine. Yeah, that's my ultimate.

8.6 Working in mental health services

One interesting outcome of the present research is that it uncovered the fact that several of the women in the study eventually worked in the mental health sector, due to their own experience of mental distress. Certainly, in Aotearoa/New Zealand in the 1990s and early new millennium, there has been a move, as a part of the reform of the mental health workforce, to including people with psychiatric histories at all levels in the mental health workforce (Ministry of Health, 2008b.) One participant found that her experience of mental distress had a positive by-product in that it led to work as a mental health peer support worker:

Like, you can't be a peer support worker if you're not a nutter. You have to be nuts to get the job (laughs.) I remember saying to Mum, when I rang up to tell her I got this job, "who would have ever thought you'd get a job because you were nuts" (laughs.)

Her surprise and ebullient response to being able to get work based on having a psychiatric illness is evident in her laughter and her ironic use of the words 'nutter' and 'nuts.' Like the participant above, another participant found that being part of a mental health support group led to employment based on her experience of mental health services:

Um, yeah, I think that's one of the best things that happened. I'd been diagnosed as bipolar for about two years before I was introduced to a bipolar support group and that was the best thing that ever happened to me because I met other bipolar people. That was when I was invited by one of those people to join a consumer strategy group, and it was from the strategy group that I was invited to join the X Committee [names government committee concerned with mental health], a consumer group, you know, elected from there, and that is a paid position. You're working with the Clinical Director of Mental Health, the General Manager of Mental Health, the Funding Planner of Mental Health and so on, and all my jobs that I do, they've actually all come from that.

The women who ended up in the mental health workforce in this study found this a positive experience. They learned new skills. For example, the following participant learned to develop effective boundaries for the first time:

And one of the things I've learned from working in mental health is you have to put up really strong boundaries around yourself and I'm getting really good at it.

For another, working in the mental health sector, because she was privy to a lot of knowledge around psychiatric conditions, gave her a retrospective sense of understanding of her struggle trying to work while psychiatrically unwell:

I actually never really acknowledged the effect that mental illness had had on my life until I started at X [names government funded public health project with a focus on mental illness.] And it was only when I was working in an environment where it was really supportive that I started to think 'gosh, now I know why I've had trouble in my working life.'

Similarly, another participant found that working in the mental health sector provided her with opportunities to come to understand her own unwellness and also explore approaches to 'recovery.' Working in the sector gave her the tools to identify what had been wrong in her life for a long time:

I think my journey with the mental illness of depression has been a long one but I've only in the last five or six years really acknowledged it for what it is. And so that probably has been spurred on by the fact that I was working in mental health, in the mental health area and I was become - , I was constantly having been made aware

of mental illness and the impact that it had on people's lives and all that kind of stuff. And so I think that, um, yeah, before then I think that I just trotted along being involved in the mental health field has made me, given me opportunities to look at other things that can work as well, and so I'd want to try that and I'm not as hung up on - I talk to people more about it than I used to.

What was revelatory for the following participant was the fact that, working in the mental health sector, she came to feel that it was okay to be different from the mainstream norm. She was able to not only disclose her 'mental illness' but express it at work when it surfaced:

Yep, and kind of working where it's, I guess, feeling safe to not be normal, if you know what I mean ... Yeah, basically not having to brush it under the carpet.

One participant was similarly able to experience her mental distress at work and have her external persona be more congruent with how she was feeling inside because she worked in the mental health sector. She acknowledges that she would probably not be able to admit to having a 'mental illness' if she had not worked in the sector already:

I think because I work in the area of mental health it was accepted that some days I'd come in and just have a bit of a meltdown and other days I'd be okay, so yeah.

Another participant has worked in the sector for so long now that she is able to influence policy at the highest level:

I have been involved ... with the mental illness sector since 1982 so that's 25 years there (pauses) or it was 1980, 1979 really ... I was actually [recently] working for the Mental Health Commission two days a week helping ... write our vision for 2020.

One participant believes that there is an attraction to working in the mental health sector for people who experience psychiatric issues, but that there are also dangers due to the level of trauma that can be experienced in that setting:

When I went into working in mental health, I found it traumatising and I certainly saw that experience going on with other people that came in. I constantly saw it. People are drawn in to mental health often because they have their own issues or they have family members with issues ... It was interesting and challenging when I first went to my new job because it was a mental health organisation. I - I did have some definite issues about going and talking about mental health all the time. I certainly wouldn't have considered myself a 'consumer' [service-user] at that time though later I may well have done. But at that stage I didn't even know what a 'consumer' was. It wasn't in my repertoire. I did find it to be quite traumatising being surrounded by the talk of mental health issues.

Another participant echoes these concerns. She sometimes wished her workplace focused less on how she was feeling. Ultimately, however, she appreciated the fact that working in

the mental health sector gave her an ability to be open at work and sympathetically cared for by her organization:

So, yeah, they've been fantastic and just, I mean, there's part of it that's a little bit - there's a disadvantage to it because everyone here is so open. I - it gave me license to some days maybe come in and talk a little bit too much about it, whereas sometimes I wish that maybe people didn't know, so that I could just sit behind my computer and do stuff and not share that sort of thing. So it's kind of, yeah, sometimes it could be a bit of a disadvantage because people are too caring and too 'how are you going?' and that sort of stuff, but, I mean, I'd rather that than the other sort of thing, I think, in the long run.

Of all the women in the study involved in the mental health sector, one participant provides a quite different approach. She has clearly compartmentalised being someone with a 'mental illness' and from being a 'professional'. Unlike the other women's accounts, there is no sense from her that these do not need to be mutually exclusive:

My last job lasted for eight and half years which is the longest I've done anything except stay clean and it was working in another community health service working a lot with refugees and people who experience mental illness and people who experience difficulties with drug and alcohol issues, and I now work for a government organisation. I've been employed as a health professional. I haven't been employed as a person who has experienced mental illness.

The reason for this difference in viewpoint from the other participants may be due to personality or may be due to the fact that she worked less in policy, management and health promotion and more in clinical service provision than the other participants working in mental health. It is not clear, however, from the data what the reason for this difference is.

8.7 Summary

This chapter presented the data from the participants about how they approached vocational issues after a diagnosis of psychiatric illness. It shows how influenced they are by the 'Protestant work ethic' and the ways in which this has caused a sense of loss for many of them. The women show versatility in negotiating their way back to work, adapting to having a psychiatric illness and learning to reorient their career development to fit their needs. Key support at work from a mentor figure was useful and the transition back to work seems to be more successful when accommodation issues are addressed early by the workplace.

Workplaces seem to be most willing to help the returning worker when they first come back to work. There is a strong sense of vocational identity being tested and sometimes altered as the identity of being a person living with a psychiatric illness challenges old ways of working. The difficulty of this adjustment is palpable in the women's accounts but so is the sense of agency that provides them with the resourcefulness to make adjustments in order to maintain a working life. Work obviously plays an important role in the women's self-concept and needs to be managed in order for them to feel socially competent as human beings. Some of the women have transformed their work lives by entering a new profession in the mental health sector based on their experience of mental distress. This seems to be a positive step for them. The women seem pragmatic in their aspirations and not prone to fanciful career daydreams, though there could also be an unwanted but accepted reduction of ambitions that has come from knocks to their confidence in their abilities and doubts about managing the symptoms of their 'mental illness.'

PART E – DISCUSSION AND CONCLUSION

CHAPTER NINE

Discussion and Conclusion

9.1 Introduction

The present study utilised a grounded methodology to explore the vocational and life experiences of a particular group of women in Aotearoa/New Zealand who have been diagnosed with a psychiatric illness. The women were predominantly P•keh•, though two women were tauiwi and one identified as having M•ori heritage. Several of the women were lesbian or bisexual. There were no co-morbid illnesses identified alongside psychiatric illness except for accounts of arthritis. Symbolic interactionist and discourse/narrative analysis helped generate theory in terms of women's experience of psychiatric illness of the issues around employment, work and their 'life-careers' as women. This theory is explained in the six key areas of discussion outlined below. How participants make 'sense' of their experiences and experience their life-career as social beings became an important aspect of the theory generated from the data. It should be noted that the women's narratives did not convey explicit gender role identification or signs of feminist politicisation. Nor was any explicit data relevant to lesbian and bisexual women's lives generated. The women clearly spoke as members of a group of people who have psychiatric diagnoses and explored both negatively and positively the impact that such an identification had on their lives.

This purpose of this chapter is to distill the salient points from the wealth of data produced from the data collection in the present study. It should be noted that broadly, the data presented in the women's narratives are consistent with existing literature. Despite this, implications for career counsellors, policy-makers and researchers can be drawn that

indicate new approaches to current policy and practices and indicate fruitful areas for future research.

The data have been previously presented thematically in Chapters Six through Eight under the linear presentation from 'Getting unwell and getting help,' to 'Getting well' and then 'Getting back to work.' As a result of undertaking the present research, it is possible to posit for discussion the following six key ideas based on the participants' responses that were outlined in those chapters.

- 'Madness' is different from 'mental illness' due to a symbolic interaction with others and the ritual process of diagnosis.
- The idea of genetic endowment of psychiatric illness is accepted by the women in the present research.
- Labelling is a powerful social phenomenon that has affected the women both positively and negatively.
- Participants' 'literacy' around mental health issues creates agency around psychiatric diagnosis, medication, and other treatment options.
- A mentor figure in the workplace and accommodations to manage work and psychiatric symptoms are regarded as very important by the women.
- Renegotiating vocational identity while accepting hegemonic discourses around work is central to positive employment outcomes for women with experience of mental distress.

Discussion of these salient points is followed in this chapter by a section on implications for career counsellors, policy-makers and researchers.

9.2. 'Madness' is different from 'mental illness' due to a symbolic interaction with others and the ritual process of diagnosis

In the participants' experience of mental distress, they can go through three different stages: self-perceived 'madness,' 'mental illness' after diagnosis and, for some of the women, socially-perceived 'madness' once their psychiatric illness is divulged to others and is not received positively (ie, discrimination.) 'Madness' seems to sit at either side of 'mental illness' in this model – on the one hand becoming an explanatory tool of the individual for their own aberrant behaviour prior to diagnosis with a psychiatric illness and on the other hand becoming a disenfranchising tool of wider society to sanction fear towards the person having been diagnosed as 'mentally ill' (Turner, 1982.) It appears that the more a person can operate socially from the perspective of having a discrete psychiatric category with treatable symptoms and accommodatable needs, then the less likely they are to be seen as a 'mad' 'other', 'alienable' from society. However, psychiatric illness is not as culturally ingrained as something to be feared as madness is, since psychiatric illness has not existed for as long as madness in the realm of social construction (Rose, 1999; Sedgewick, 1982.) Furthermore, much work has been undertaken to educate society about specific illnesses and psychiatric issues as a whole. The ability of the women to articulate their needs and maintain their self-confidence to a large degree seems to depend upon the place of discrete psychiatric illnesses versus madness in the cultural consciousness of the time in which they have experienced their mental distress, in this case the later part of the twentieth century and the first decade of the new millennium.

As Jamison (1996, p. 68) says: "I did not wake up one day to find myself mad. Life should be so simple." The time of 'madness' in the participants' narratives can unfold over a number of weeks, months or even years and signifies a time of not knowing what was happening to oneself. 'Mental illness' is seen as a time of receiving answers and understanding why one has been behaving the way one has – concomitant as this is with the requirement, by society and the medical profession, that one accepts diagnosis and

complies with treatment in order not to be seen as resistant (Pilgrim & Rogers, 1999). A diagnosis brings with it the responsibility to be an active participant in one's own treatment (Turner, 1987.) Simon terms the worldview of a mentally distressed person as "4-D" (2002, p.201.) This 4-D will always be culturally circumscribed and it is interesting that the Virgin Mary, Jesus, Satan, aliens transmitting through the television and CIA bugs inside the body are symbolically 'real' in many Western psychoses. Without being a 'social being' with cultural references at one's disposal such psychotic 'realities' could not be experienced by an individual. In this way, even psychosis can be seen as being created by symbolic interaction with other social beings; the very material produced by delusions and hallucinations is culturally proscribed.

'Madness' for the women seems to be associated with a state of which one is often only tangentially aware. It denotes a lack of social and personal responsibility. Socially acceptable meaning-making of the phenomenon is difficult for the individual and this, combined with the impact of their aberrant behaviour, can produce feelings of alienation from others or actual alienation as others reject the individual who is behaving 'madly.' 'Mental illness' is associated with a societal intervention through the medical profession – often prompted by a family member or partner (Goffman, 1961) – recognition of one's condition, and responsibility for recovery through pharmacological and cognitive intervention. From the point of the intervention onwards it is socially required of the individual that she must try to make sense of the social messages she is getting about what she has been cognitively experiencing. 'Mental illness' can be seen as social phenomena that the individual in society attempts to understand and make meaning from. This meaning-making is crucial to the person experiencing 'mental illness.' The promotion of new roles (as a person with 'mental illness' and as someone seeking recovery rather than as a 'mad' person and someone aligned with their disorder) can lead to a more positive sense of self.

'Madness' can be experienced by a mentally distressed individual as subjectively rational behaviour and beliefs that are often valued and wanted by the individual, while

society sees it as irrational. 'Mental illness' requires agreement subjectively from both society and the individual, to some negotiable degree, that the 'madness' was irrational and unwanted. The self must reject the 'madness' to some degree and accept the rubric with which 'mental illness' is diagnosed in order for it to become for them a 'mental illness'. The diagnosis must be both given and accepted through negotiation and the exchange of symbolic meanings around 'madness.' Some social responsibility is required from the point of diagnosis with 'mental illness' onwards, though how much the individual shoulders this challenge might well reflect how integrated or alienated they continue to feel in society once they are labelled with a 'mental illness.'

Schmitt (1994) sees alienation as only being possible when some elements of self-determination are possible to citizens in a society. If a person can construct an idea of themselves as an individual able to make choices within the limits of their society's culture, then an identity is formed from this of the person being an individual as well as a member of a family or other such grouping. This individuation and self-determination can contribute to an agency and 'literacy' around mental distress that aides the person in taking charge of aspects of their own treatment and journey back to wellness as can be seen further on in this chapter. When a person is unable to define themselves through self-determination, however, alienation can develop as a response. Certainly there seems to be some experience of alienation, even if it is not articulated in socio-political terms (as by Millet, 1990), in the storytelling of the women in the present research. This can be seen, further on in this chapter, in some of the participants' experience of labelling and some of their struggles with vocational identity.

9.3 The idea of genetic endowment of psychiatric illness is accepted by the women in the present research

Pinker (2002, p. 202) notes that "some categories really are social constructions: they exist only because people tacitly agree to act as if they exist." Psychiatric illness has been identified as a social construction by political commentators such as Kate Millet. The women in the present research do not share this view, however. They see 'mental illness' as an ontological fact and see bio-chemistry as its basis. From the beginning of modern psychiatry in the nineteenth century, organic and genetic factors have been identified as the underlying cause of psychiatric illness, essentially giving a biological framework for understanding mental distress. This has been contested at various points since (Shorter, 1997), but is the predominant view in Western psychiatry and Western society in the new millennium, tempered as it has been by psychoanalysis and Rogerian counselling's aims to reify the individual and the impact of life events on their mental distress (Hunter & Macalpine, 1963; Micale & Porter, 1994.) What the women in the present research have internalized and accepted as 'truth' is a paradigm of making sense of mental distress which has been in existence since the 1900s (Shorter, 1997.) This view affords the women the ability to experience less shame around their own diagnoses of a psychiatric condition and their own experiences of 'mad' behaviour prior to diagnosis. The genetic, biological model of mental distress counters the moral, degeneration thesis that has also existed throughout history from the Middle Ages through to Johann Heinroth's nineteenth century psychiatric theories, and on to negative eugenics in the 1920s and 1930s in Europe and North America, and also the homophobic vilifications of the mid-twentieth century (Bayer, 1981; Gupta, 1993; Read & Masson, 2004; Scull, Mackenzie and Hervey, 1996; Shorter, 1997; Turner, 1982.)

The diagnostic and pharmacological explosion in terms of psychiatric illness categories and their neurochemical treatments (Mosher, Gosden & Beder, 2004) gives psychiatric illness an image based on biological authority that will also add to the impression that psychiatric illness is organic. The sheer number of participants' relatives in this study

who have experienced mental distress seems to back this idea up in the participants' minds, even though their relatives have often had different psychiatric diagnoses from their own. This could be explained by the fact that psychiatric diagnosis is a fast changing and evolving science (Mayes & Horovitz, 2005.) Alternatively, it could be that the relatives' illnesses were coincidental to the participants' and not signs of a genetic endowment. However, the participants' views do not allow for this as an alternative reading of this data. They clearly see mental distress as a genetic condition.

Diagnosis and treatment through medication help a biological view of psychiatry predominate today (Mosher, Gosden & Beder, 2004) and the women in the present research are clearly thinking about mental distress in these terms. This does not make them uncritical in their thinking, however, as can be seen from their approach to the issue of labelling and in their agency and 'literacy' around treatment issues in the next two sections of this chapter.

Several of the participants felt that 'mental illness' was integral to them - a fact – and as has been noted above all identified it as a medical condition: no one saw it as a social construction. This is perhaps a sign of the milieu in which each woman was telling her narrative of her life. Many women in the 1970s saw psychiatric illness as a label of oppression put on outsiders or troublesome firebrands and many users of mental health services in the 1980s also saw it as a medicalisation and problematising of a valid way of seeing the world (Gupta, 1993.) Without acceptance of a biological reason for mental distress, the process of medicalised diagnosis through use of the *Diagnostic and Statistical Manual* would receive far less compliance from the women in the present research than it does. It is difficult to ascertain how this acquiescence to a medical individualistic model has been achieved, save that today's society is a far more conservative and ideologically neo-liberal and individualist one than it was in the 1970s through to the early 1990s. Radicalism and social change have become a conservative preserve not a socialist or sociologically-aware preserve, and language of the 'self' rather than the group has become predominant through the self-help era, consumerism and globalisation. A *gemeinschaft* orientation seems to lie at the bottom of this along with increased fealty to a medical profession that can indeed

seem to 'cure' psychiatric illnesses today through symptoms control via the use of advance medications.

Nevertheless, I am in agreement with Ussher (1991, p. 218) when she says that a wholesale rejection of the medical model "is not really a step forward." The women in this study have shown that, as it stands at this time in Aotearoa/New Zealand, there is much to be gained from treatment based on the medical model. What can be said is that the medical model has itself been changed by social forces and its implementation has been modified over time by social change such as deinstitutionalisation and human rights advocacy in various forms (sexuality, disability, gender and ethnicity.)

9.4 Labelling is a powerful social phenomenon that has affected the women both positively and negatively

The ability of some participants in this study to embrace positively their labelling by the medical profession may be related to the fact that psychiatric illness has over time begun to move out of the realms of deviance in society's eyes. What is clear from the data of this study is that labels are no longer seen as things that, according to the well worn adage, should be on jars but not ascribed to people (Ballard, 1994.) They can have a utility value and symbolically are useful, when not used to pathologise or discriminate, in that they provide a 'shorthand' for understanding what ails a person. Labelling can also be a ticket of entry into a like-minded group of people from whom one can receive fellowship (for example, other people with the same classification of psychiatric illness). The *gemeinschaft* type of 'kinship' that derives from belonging to such a labelled group may be powerfully therapeutic for some, though not all, of the predominantly P•keh•/tauīwi women in the present research who have little experience of such a 'warts 'n' all' style of belonging, of being not just 'me' but also 'we.' Despite feeling that having a psychiatric illness was a medical fact, there was a lot of hope expressed by the women in the present study about recovery and optimising one's life chances. This again may come out of an illness model of where many illnesses can be

seen to be ameliorated or even cured by modern medicine. Positive labelling begins a ritual of return, creates the sense of a transition occurring, and liberates the psychiatrically ill person by compartmentalising their psychiatric illness so that it does not encompass the entirety of the person's view of themselves, or indeed others' views of them. For the women in the present research, 'mental illness,' rather than the person, often becomes objectified and acted upon collegially. Similar meanings can be shared with those who also have the label and an increased sense of 'literacy' and self-efficacy can develop. For some women in the study a group identity as 'mentally ill' people can develop which can alleviate alienation and stigma.

However, labelling is not always seen as a positive experience for all of the participants. Negative labelling locks the person into a sense of self, through objectification by others, that can then be used to proscribe treatment options which they do not feel suit them (Horovitz, 1979.) The label can have more authoritative power than the viewpoint of the individual labelled with it. Some people who have been labelled will get more freedom to make decisions about their treatment than others, for example if they have an anxiety disorder rather than a psychotic disorder. A lack of say, or a profound sense of dislocation from one's previous sense of identity, brought on by the diagnosis of 'mental illness,' can lead to alienation for those whose psychiatric illness classification is not well accepted by society, for example schizophrenia or borderline personality disorder. Despite the attempts of some participants in the present research (those with anxiety and depression) to differentiate themselves from 'those people' (the extremely and chronically 'mentally ill' with 'harder' diagnoses such as schizophrenia), what some of their comments do show is that even anxiety and depression can lead to deep alienation from mainstream society and also to life threatening situations (suicidal ideation) due to *anomie* (Durkheim, 1951.)

If the person over-identifies with a label they can carry it into all areas of their interaction leading to learned helplessness and isolating, antisocial behaviour that is antithetical to community living and the perception of full personhood by others (Musolf,

2003.) The women in the present study do not appear to over-identify in this way. The building, through negotiation with others, of a 'self' outside psychiatric illness is an important part of avoiding alienation and anomie, and the women seem to do this well, but friends from before the psychiatric diagnosis seem to be lacking in the participants' data in the present study. 'Mental illness' diagnosis and 'recovery' seem to be terrains negotiated with key people other than friends – it is negotiated through key relationships with professionals, family and partners, as well as workplace mentors. All of these key individuals appear for the most part not to make predominantly negative assumptions about the psychiatrically ill in society. Furthermore, this shift in society's thinking from a deviancy discourse to an illness discourse (Gupta, 1993; Meighan, 1981), while not necessarily reflecting all of society's views on psychiatric illness, appears, when exhibited by key people, to assist the person experiencing psychiatric illness to cope with the labelling process well and even use it to her advantage. As a symbol exchanged through social interaction, psychiatric illness appears to be seen in the lives of the women in the present research not as a social violation of norms but as a manageable, though lamentable, life event. There is no explicit labelling of the women in the present study as 'hysterical' or 'neurotic' and very little implied criticism of the women by others which might be construed as sexist. Issues of womanhood, mental distress and psychiatric misogyny typical of other eras do not arise from the data.

Certainly the participants did go through periods of self-doubt and grief around their identification as 'mentally ill.' The reinstating of respectability by a significant other (family member/partner) or mentor is described by the participants as crucial. This is undertaken through a dialogical act in which a positive sense of 'self' can be recovered. Not all of the participants' family and partners provided this but for each of the women a significant few key people did. Some of the participants were surprised to discover which significant others in their lives helped them most. It appeared that the most helpful people had a 'literacy' around psychiatric issues which was congruent with that of the participant, as will be seen in the next section.

Externalising the experience of mental distress by embracing their diagnosis, working to recover their selfhood from their 'madness' and learning to see the positives in the labels they acquire appears to be important for all of the women in the present study. Affirmation of the 'self' through positive social interactions (while also battling the symptomology of their psychiatric illnesses) is key, in these women's stories, to their overcoming the disabling weight of the stigma that can occur through labelling. It occurs predominantly through interactions with family, partners, psychiatric professionals, key workplace figures and consumer 'peers', and helps to provide the women in the present research with a communal language and a critical 'literacy' that they can use to increase their self-determination and find social role valourisation as women experiencing 'mental illness.' This notion of 'literacy' and the agency which it provides is discussed in the next section.

9.5 Participants' 'literacy' around mental health issues creates agency around psychiatric diagnosis, medication, and other treatment options

Mental distress clearly created an unwanted and unforeseen vocational and life-career transition for the participants in the present research. Death is not a single ontological event (heart failure) or a single symbolic event (a funeral.) It occurs symbolically in terms of the exchanging and eventual giving up of roles in a specific cultural milieu. As Harre puts it: "the ending of a life trajectory involves a complex interaction of processes closing off different aspects" (1993, p. 216.) Disability through mental distress or the 'violence' of an acute single episode of psychiatric illness upon a person's selfhood created an early death in respect of some social roles for the women in the present research. The process of becoming 'mad', being diagnosed and treated as 'mentally ill' and retaining or regaining a vocational and social identity is a complex closing down of and opening up of different aspects of selfhood and social role adoption. What seemed to be crucial for the women in the present study in order for them to traverse the dangerous terrain of renegotiating selfhood and social roles in the light of their diagnosis and labelling was a 'literacy' around what they were experiencing.

This led to agency and the ability to transform where necessary. Those who did not have this 'literacy' were more likely to be stuck in grief for old roles and old concepts of selfhood. Integration of 'mental illness' into selfhood and the agency to renegotiate and modify social roles relied upon such a 'literacy.'

The term 'literacy' has been used elsewhere in mental health circles (Field, Highet & Robinson, 2002.) It is a useful term to describe knowledge acquisition and utilisation and the ability to view psychiatric illness critically. Such 'literacy' does not necessarily have to be hegemonic. It can run counter to professional mental health views and be politically and culturally shaped. It is a conceptual architecture for dealing with social issues. All of the women in the study showed a similar type of 'literacy' to one another around 'mental illness' issues. Whether it came from their family experiences, their own experiences of treatment or from wider public knowledge bases is difficult to say. However, it is clear that the participants drew strength from the opinions and experiences of those who had had similar experiences to their own. Perhaps the sense felt by some of the participants of belonging with others who have experienced mental distress – with whom participants might not otherwise have chosen to interact – and sharing a similar worldview comes out of having shared the same 'ritual' (Burns, 1992) of going through the mental health system and understanding one another's codifying of experience as 'mental illness' or 'madness,' stigma and discrimination, treatment and psychiatric care. This creates a *geimenschaft* sense of collectively based on a 'kinship' created through shared meaning, rather than the usual rationally based relationships of *gesellschaft*-oriented Westerners. Such a kinship can provide a sense of 'safety in numbers' and give people with psychiatric illness more of a sense of self-efficacy in terms of voicing their needs or exercising their options in terms of treatment and recovery. Also working in a mental health service, or in mental health promotion, afforded some participants a more sophisticated view of their situation as people with psychiatric illness. It also provided those who worked in these fields with clarity around their vocational problems due to the openness of many of these workplaces to address psychiatric issues in their employees.

Recovery and resilience-development are perhaps less the ability of doing things for oneself and more the ability to control and decide one's own life utilising the support of others when required (Oliver, 1989a.) Agency and self-determination are an important, though sometimes overlooked, part of recovery and resilience-development (Oliver, 1989a) even while the person with a psychiatric illness still needs the support of others to exercise their full citizenship rights. The women's literacy around psychiatric categories, medications, and positive vocational accommodations to help them deal with their psychiatric illness was clear in the present research. This literacy enabled the women to exercise an agency around getting their choices acknowledged and their opinions respected when it came to taking medication. It provided them with the strength to voice strong opinions about formal psychotherapy and counselling though this did not necessarily lead to greater access to such therapy. Rather, many of the women found informal 'talk therapy' themselves through mental health peer support groups and church groups. The women showed a weaker sense of agency around the changes psychiatric unwellness brings to their abilities to work. However, in terms of vocational 'literacy' around psychiatric issues, they did seem to know what they needed in terms of accommodations to make work possible for them, as will be seen in the next section of this chapter.

The data analysis in the present study shows how reinvention after psychiatric illness diagnosis is hegemonically circumscribed. Self-concept, in symbolic interactionist terms, is a reflection of one's interpretations of one's 'self' in relation to interactions with other social actors. It can be severely affected by the roles society creates for a person through ongoing dialogical acts of meaning-making and the socio-cognitive processes affecting an individual's behaviour. The adoption of a problematic role and social status, and the cognitive dissonance created by such an act, must necessarily impact negatively on the self-conceptualising processes of an individual. The participants in the present research are seen to be struggling to shake off the passive roles assigned to the mental patient by structural forces in society. What is encouraging is that they have 'literacy' around the issues affecting

them and that this enables them to use agency to counter the traditional passivity of mental patients in terms of the professional prescriptiveness of pharmacological interventions and lack of access to other forms of recovery tools. The women are seen to be struggling to develop a new role-type of the psychiatrically ill person that is more acceptable to their need for a positive sense of 'self.' One important aspect of the data that will be explored later in this chapter is the fact that the women nevertheless see reinvention of their sense of selfhood and citizenship as being strongly work-based and requiring as little support in terms of government sickness or disability payments as possible, as can be seen in 9.7.

9.6 A mentor figure in the workplace and accommodations to manage work and psychiatric illness symptoms are regarded as very important by the women

Participants had varied experiences of 'coming out' and disclosing their 'mental illness' in their workplaces. Some chose to predominantly pass as 'normal.' 'Passing' as 'normal' is a task undertaken by some people who experience stigma due to the label of psychiatric illness 'spoiling' their identity, according to Goffman (1963.) Those women who could 'pass' in this way often did. Many, however, had been so unwell that it was impossible for their workplaces not to know what had happened to them. They could not 'pass' as normal. What they did experience, however, to a large degree, was a conferring of symbolic normalcy from significant workplace figures if they returned to their existing employment. That is to say that they were not 'written off' by their workplaces but were granted accommodations, often generous ones, for example flexibility of working hours, working from home, part-time options, and support people when delivering workshops. This enabled the women who returned to their original place of work to, for the most part – for not all had overwhelmingly positive disclosure experiences – to be treated as though generically ill and in need of recuperation and support. A lot of their self-efficacy and positive self-regard could be maintained through this process. However, it was usually the place of a key benevolent individual with sufficient prestige and power in the organisation to bestow this symbolic

normalcy on the woman returning to work, rather than a workplace-wide policy or a reflection of generally socially relaxed approaches to people with psychiatric illness remaining in work. It should be noted, that, perhaps, the ease with which a few of the participants interacted with M•ori managers (and found them a long term nurturing component during their illnesses and 'recovery') stems from the fact that M•ori operate from a more *gemeinschaft* orientation that P•keh• do. The fact that key individuals (sometimes specifically identified as 'naturally' supportive because of the very fact that they were M•ori) did come into the plot of the women's narratives, much like a 'knight in shining armour', had a profound effect upon the women's abilities to retain their previous employment. Not all of the women had such an opportunity and, for those who did not, there is a sense conveyed of unhealed loss of vocational identity or a monumental struggle to refind a footing in the world of work.

For the women who discussed M•ori in their narratives, an appreciation of M•ori *gemeinschaft* values towards manuhiri,⁶² as well as their own people, can be seen to develop through direct experience of the •whi⁶³ M•ori can provide to those struggling with psychiatric illness. Some, but not all, P•keh•/tauiwi participants might therefore be placed further towards the centre of the collectivism/individualism continuum than they might have been without both a sense of community with other people with 'mental illness' and without experiencing support from the tangata whenua.⁶⁴ Mentors and fellow sufferers can help a person with experience of living with mental distress still feel like a valuable human being, despite diminished capacity and agency.

Old workplace hierarchies and authoritarian approaches to personnel management, while still persisting, have also been eroded. The locus of control for the worker in Aotearoa/New Zealand today is still more often external than internal – depending on their profession and professional status. There is nevertheless more flexibility in the workplace and greater acceptance of depression and anxiety. This makes disclosure, continued

⁶² Te Reo M•ori for guest or visitor.

⁶³ Te Reo M•ori for love or care (bringing with it a sense of hospitality and concern for welfare.)

⁶⁴ Tangata whenua in Te Reo M•ori means 'people of the land' or Indigenous people, ie, M•ori.

employment and workplace accommodations more likely. Despite this, all of the women, even those with a knight in shining armour/mentor figure, did experience the hardship of holding onto their vocational identity, coping in their workplaces once the initial flurry of concern and support from key mentors had subsided, or coping with the expectations of their role while also dealing with mental distress and the emotional and cognitive work required to manage it. It is clear that the effort required to cope vocationally and socially while experiencing psychiatric illness is needed long after the return to work. However, the impact that a positive return to the original workplace had on many of the women in the present research shows the importance of vocational role continuity in their recovery trajectory. There is little in the existing literature that looks at this. Most of the literature is based on interventions with those who have lost their vocational momentum and this reflects a preparation and placement rehabilitation model rather than a career retention/career development model. Those participants in the present research who stepped off the path of their previous work struggled much more, though ultimately most of them did reframe their vocational view of themselves and rebuild their vocational identity in a new mould of which most are extremely proud. The renegotiation of vocational identity is the subject of the next section.

9.7 Renegotiating vocational identity while accepting hegemonic discourses around work is central to positive employment outcomes for women with experience of mental distress

Despite mainly positive experiences of diagnosis and some good experiences of medications and treatments, participants were keenly aware of the losses they had experienced due to psychiatric illness and this was clear from their accounts of the challenges they faced vocationally. A different style of data collection might have produced data which was more gender-specific. That said, the present research will benefit women and girls in Aotearoa/New Zealand by producing a specifically Aotearoa/New Zealand theory

of the impact living with psychiatric illness has on women's work lives as well as the impact the place of work in today's society has on their experience of 'mental illness.' While the women did not themselves talk explicitly of gender issues, their career experiences are embedded in gendered social opportunities and vocational patternings. They predominantly worked in teaching and the social services, or moved across to these traditionally 'female' professions to avoid work stress after psychiatric diagnosis. They also predominantly had had portfolio or kaleidoscope type careers, even while internalising the traditionally male linear model of career as the 'norm' from which they had had to necessarily turn away due to their 'mental illness.' Certainly, many of the women felt vocational loss and identity confusion when their career plateau-ed due to their psychiatric illness's needs curtailing their opportunities to carry on up the perceived career ladder.

For the most of the women in the present study there was a strong sense of work being a compulsory facet in their lives and quite a lot of distress around having a psychiatric illness and not being able fully participate in the workforce to the capacity that they feel is expected. The ability to work with the experience of mental distress can be an important factor in individuals maintaining a sense of positive identity and membership of society so that further alienation does not occur beyond that which may be experienced through diagnosis and disclosure of psychiatric illness to family and friends.

For those participants – the majority - who have found maintaining a worklife difficult, there has been little re-evaluation of work as a compulsory component of modern life and little critical thinking about this. Work is accepted as normal and worthwhile. Perceived failings at work are seen as personal failings, not the failure of society or of the milieu in which the women live. An awareness of the impact of one's social context has been present in career development research since Roe's work in the 1950s. In 1956, Roe said that our inheritance as social beings goes beyond wealth, prestige and family background. To Roe, it also included the state of the community, the nation, and the part of the world in which the individual is born and lives, and has the power to severely limit the ability of individual

citizens to express themselves socially and vocationally (Lunneborg, 1997.) All of these elements contribute to opportunity as well as a lack thereof for each person living under their influence. They impact especially on the lives of people of disadvantaged status – such as women and the psychiatric unwell – but also impact on every citizen's life. Lunneborg (1997) notes that we only need look at how different a nation is in times of war or depression compared to prosperity to see that this must have a large bearing on individuals' opportunities to thrive. It is interesting that little critical analysis of societal power, economic times and socio-cultural mores was provided by the women in this study. It is my supposition that this is not engendered by the research methodology used but rather reflects the more passive and individualistic nature of women in the early new millennium in Aotearoa/New Zealand.

It should also be noted that while Kate Millett is deeply aware of the role of society in disabling her as a woman experiencing mental distress, the women in this study had little of this gendered critical analysis. They did not speak of themselves explicitly as gendered beings or create narratives in their interviews about the ways in which women's issues impacted upon them. It was only in terms of disclosure that specific acknowledgement of a lesbian issue, that of 'coming out', was expressed. This is perhaps due to the neo-liberal times in which they live leading to less identification with women's political issues, or perhaps due to less feeling of alienation from society as both women and also as people with psychiatric illness due to the work that has been done by feminism for women, the rights that have been won and also the work in the last decade to de-stigmatise psychiatric illness, treat people in the community and support individuals with psychiatric illness to recovery through vocational interventions and social support. As Inkson and Elkin note:

Career theorists have long recognised that careers were influenced not just by the desires of the career-making individual (a psychological view), but also by external constraints as diverse as labour supply and demand, organisational structure, gender, and family circumstances (a sociological view). (1997, p. 416)

One way of looking at the behaviour of the women in the present research who tried to avoid welfare payments of one kind or another is to see that they do not share Marshall's view

(1963),⁶⁵ albeit a British one, that social services are in fact part of the package of rights afforded citizens in a capitalist democratic country in which formal and rational relationships (*gesellschaft*) have replaced a previously communally-based social order (*gemeinschaft*) (Mishra, 1977; Nisbet, 1970.) While, at some level, the women in the study may understand that the option of social service help is open to them, they seem to eschew it. While this dislike of relying on others for help may be indicative of the individualistic Western psychology of the participants, it may also derive from a particularly Aotearoa/New Zealand mindset. As the National Research Advisory Council (1981, p. 6) puts it, full employment became a “fundamental national value ... a belief cherished in New Zealand.” Aotearoa/New Zealand did have full employment in the middle decades of the twentieth century. Therefore, there is a ‘hangover’ belief in the Aotearoa/New Zealand mindset today that unemployment is somehow a transgression. With neo-liberal politics having made their mark on the collective psyche of New Zealanders since the mid-1980s, and with the threat of national bankruptcy only narrowly avoided in the years just prior to that shift to the right, one can see that there may be an especially keen neurosis in the Aotearoa/New Zealand psyche *vis a vis* not working. This would make sense of the participants’ concerns since they seem to go against another Aotearoa/New Zealand view which is that Aotearoa/New Zealand was the country of ‘cradle to the grave’ welfarism and state intervention – a view that one would expect to sit more comfortably with the idea of seeking social assistance.

9.8 Summary

To summarise, data analysis of the research participants’ interviews supported six major areas for discussion. The idea of genetic endowment of ‘mental illness’ is accepted as an ontological fact by the women in the present research, as is ‘madness.’ To the women, ‘madness’ is different from ‘mental illness’ and this delineation is centred around diagnosis.

⁶⁵ Marshall sees citizenship rights operating at the civic (personal liberty and legal equality), political (the right to vote and represent politically) and social (welfare support when needed and access to social life) Levels. Various types of individuals might forfeit these rights of citizenship for a time.

Diagnosis transforms amorphous aberrant behaviour into a modern illness category which is perceived as treatable. This diagnostic act creates labeling. Labelling has affected the women more positively than the literature would have us expect to be the case. The women show clear signs of self-determination and 'literacy' around their treatment options. They have an expectation of themselves that they should be co-drivers in their 'recovery' alongside those psychiatric professionals whose judgment they trust (and there appear to be many more of these than the literature would lead us to expect.) The women showed a clear 'literacy' around psychiatric issues such as diagnosis, medication and other treatment options. The relative ease with which most women in the study coped with diagnosis and found medication and non-pharmacological interventions useful (compared to women such as Kate Millet in the 1970s), as well as having positive support in both the workplace, their home life and through others who experience psychiatric illness, may provide some underlying reason for the mainly positive outcomes for these women in the world of work.

Alliance with a mental health professional is mirrored by alliance, in many of the women's stories, with a mentor figure (or enabler/supporter) in the workplace. Accommodations to manage work and psychiatric symptoms had a profound ability to keep the women in their existing professions. This had a positive impact on issues of economic loss and vocational identity erosion. Renegotiating vocational identity while accepting hegemonic discourses around work is central to positive employment outcomes for women with experience of psychiatric illness and this provides career counsellors with fertile though difficult terrain in which to work with people with psychiatric illness, most of whom clearly want and need to work as part of their mental health maintenance and social recovery from a traumatic life event – the experience of mental distress.

In terms of the social and vocational experience of women diagnosed with a psychiatric illness in Aotearoa/New Zealand at the present time, there is much which still needs improving, but much which has obviously already been improved. Career counsellors and those who support people with psychiatric illness can either try to deconstruct and challenge the hegemonic 'Kiwi' discourse around work or they can work from the position

that society and the individual is 'at' with regard to work. One seems a monumental task and the other a missed opportunity to help individuals destigmatise themselves vocationally. Perhaps an element of both approaches would be valuable but career interventions that are discursive in nature are few. So the following section provides advice to career counselors that may help them work with such clients (in order to help them achieve a positive vocational sense of 'self' and subjective vocational success) in a way that both challenges and takes account of the internalized structural societal forces which constrain them.

9.9 Implications for career counsellors

Inkson and Elkin (1997, p. 408) note that the concept of career is generally divided into professions, trades and jobs in modern times, with professionals being the only ones that might be considered to have a 'career pathway.' There is also, of course the more holistic interpretation of career as one's whole life, not just one's occupation. In terms of the occupational realm (despite the range of occupations available to people proliferating as technologies advance and knowledge economies come into being) the old worldview of certain work being a 'career' and other work merely being a 'job' has continued in the general public's consciousness. Not all of the participants integrated their experiences into their vocational identity successfully, perhaps because they held this old worldview and were unable to see their life as their career and 'mental illness' as a normative part of that career for 20 to 25 percent of the population.

It might have been useful for others in this study if Driver's notion of career types was more readily part of 'conventional wisdom' about careers. Driver (1979) sees career as having several types – steady state (eg, GP), linear (the traditional notion of a career ladder in a single field), spiral (staying in management but changing fields of work) and transitory (based on opportunities and changes in career likes and dislikes). However, the women in the present research were predominantly influenced by a linear sense of career. They felt

that they had had to adapt this– ie, with flexibility or autonomy or not taking on management roles – in order to cope vocationally with their psychiatric illnesses.

Some of the participants' struggles to cope with the limitations that their psychiatric illnesses have placed on them vocationally may be because they are challenged by having to change the type of career anchor they were relying on since starting out in the workforce. According to Schein (1978)⁶⁶ there are five types: the managerial anchor (related to working with others in a supervisor or leadership way, eg, supervisor, teacher); the technical anchor (seeking to develop skills and expertise in a certain field, eg, potter, electrical engineer); the security anchor (a stable predictable work environment, eg, industrial sewing, cooking); the autonomy anchor (where freedom is the essential requirement of a work setting, eg, truck driving, traffic warden); and the entrepreneurial or creativity anchor (where creating and running a one's own business, or sector of a business of some type, is the main desire of the individual, eg, real estate agent, market vendor, artist.) What some of the participants might discover, if looking at their career anchors, is that having a psychiatric illness has meant they must struggle against their existing career anchor or be prepared to change it to fit in with their health needs.

Hackett (1993) advocated career counselling as part of an holistic⁶⁷ mental health intervention programme. A single episode career intervention is unlikely to be fully effective in terms of careers work with people who have or do experience psychiatric illness. A more multi-faceted approach may be required involving more sessions and perhaps a team approach in which mental health staff and career professionals work in alliance with one another on personal and vocational issues to assist a client with a career issue (Hackett, 1993.) What is clear is that medication issues and illness symptoms should be understood by career professionals so that they do not attribute psychiatric illness or medication side

⁶⁶ It should be noted that Schein's study was undertaken with a relatively small sample of men. However, it would appear to be a useful construct for most people to use, open as it might be to addition in order to make it 'fit' with most workers.

⁶⁷ Patton, McMahon and Watson (2003) advocate a holistic context-rich approach to career counselling which explores systems of influence upon the client and a focus on aligning a career intervention with the personal meaning-making of the client.

effect symptoms to lack of motivation or indecision (Bond & Meyer, 1999.) Professionals need to have an understanding of the place stigma and discrimination (Garske & Stewart, 1999; Peterson, 2007; Peterson, Pere, Sheehan, & Surgenor, 2004), multiple minority status, and grief and loss in the psychology of the individual with a psychiatric illness with whom they are working on career issues.

Essentially, any career intervention with people who experience psychiatric illness needs to include an integrative consideration of both “career and personal themes” (Nevo & Wiseman, 2002, p. 227.) A narrative approach to revealing the impact of psychiatric illness upon careers and a developmental life-span approach to looking at points at which psychiatric illness led to non-normative experiences in relation to perceived normative life-span experiences would both be valuable. Psychiatric illness from a career development perspective could be viewed in this way as a disruption or delay of normative development at various points across the lifespan. However, more important is an acknowledgement of contemporary notions of career as ‘life-career’ and not just vocational concerns. Acknowledgment of this could help develop a career intervention that aims to deconstruct dominant discourses of ‘non-normative’ development in terms of psychiatric illness. This could be hugely empowering for clients as they come to see their experiences as part of a normative fabric of human experience and use this knowledge to develop resilience and agency in terms of how they interact with others in society. Furthermore, career counselling is by nature short term and therefore a revisiting of career counselling at various intervals in the recovery process of the person with psychiatric illness would be advisable.

What the women in this study showed is that formal career counselling was not part of their experience but that on the job mentoring did play a large part in them remaining successful vocationally in their eyes. Without being overly prescriptive, it is to be recommended that a more aggressive outreach of mainstream career development services be undertaken by organisations such as Career Services Rapuara and the Ministry of Social Development, rather than a reliance solely upon vocational rehabilitation programmes. While

the notion of a career counsellor as an 'expert knower' has largely been dismissed in today's career practice, the value of the mentoring function of managers in the workplace and the facilitative, enriching and positive change-focussed role of more developmental and constructivist forms of general career counselling practice – which depend less on the traditional directive style trait and factor practices – should not be underestimated (Parker & Plimmer, 2003.) Such an approach is more client-centred, "culturally responsive" (Parker & Plimmer, 2003, p. 53) and engaged. It is less directive and test-based, with assessment being more subtly integrated into the counselling process (Patton, McMahon & Watson, 2003.)

As Aotearoa/New Zealand authors Plimmer and Parker (2003, p. 54) note, psychological distress should be factored into the career counselling equation rather than solely focussing on "very rational issues based on prospects, money, opportunity for travel or some other sensible attribute." Since so many of the population are deemed to experience mental distress at some point in their lives, it makes sense that career counselling services use tests as only one aspect of a suite of approaches that focus on the complex storied personhood of the client and not just their skills, interests and values. A constructivist approach, married with solution-focussed strategies, could be the key to producing positive outcomes for clients (Miller, 2004b.)

Miller (2004b) advocates the systems theory approach developed by Patton and McMahon (1999) as the best method for integrating constructivist approaches into career counselling. The counsellor and client are required to come to understand the systems of meaning that they have developed due to sociological and psychological aspects of their everyday selves – such as gender, age, value system, religion, and disability. Larger structural influences derived from the era and country in which the client's life-career is acted out are to be considered – such as the economic downturn current at the time of writing up the present research. Meaning-making around the systems of influence in a client's life can lead to the development of "meaningful stories" (2004b, p. 52) that lead to a personal theory

of career development. Such an approach fits neatly with symbolic interactionism in that it challenges the counsellor to identify their own personal life-themes (Savickas, 1995; Miller, 2004b) and unpick the discourses that they use to construct their own personal viewpoint. The counsellor can then encourage the client to unravel the systems of belief and discursive practice that have led to their own personal viewpoint and meaning-making about their personal and vocational life. Clients can then adjust their 'story' as myths are unpacked and values and beliefs are acknowledged and operationalised through career exploration.

Savickas has called for a convergence of career theories and such an approach as that outlined above – which still can have a role for card sorts and testing, etc, though not as the predominant tool. Certainly career researchers and practitioners have taken up the challenge of using both objectivist/positivist and constructivist approaches (Chen, 2003; Savickas, 1995.) It seems that career counselling as a practice is, at this time, ready to work with the person troubled by mental distress in a fruitful and solution-oriented way since both the profession of career development and that of mental health support is now, more than ever, client-focussed and open to valuing the social and psychological factors that are at play alongside any discreet diagnosis of psychiatric disorder in an individual. Counselling is a way of coming to know oneself as Parsons, the acknowledged founder of career counselling, himself understood (Chen, 2003). From a symbolic interactionist perspective, such self-knowing is only a construct. However, in a world of constructs, there is value in such a self-knowing no matter what discourses shape it, as long as the individual is dynamically and positively aided by such self-knowing so that it aids them in their recovery and resilience-development both vocationally and psychologically.

To conclude, the women in the present research have shown that focussed assistance from mentors has been invaluable in their recovery. Rather than relying upon fortuitous happenstance to receive such invaluable support, people in Aotearoa/New Zealand who experience career difficulties due to psychiatric illness might be better served with targeted assistance from formal career services liaising with mental health services

while they are still active in the community and functioning vocationally, rather than as a rehabilitative measure after severe and often hospitalised experience of psychiatric illness. What this study has shown is that positive one-on-one support is invaluable and can make the difference between continued fulfilling employment and a downward spiral of vocational attrition.

9.10 Implications for policy makers

Ballard makes the point that life-story research does not provide specific and generalisable findings but that it increases “the range of knowledge” (1994, p. 302) available to someone who wishes to use the research to inform their practice. Findings from such research remind policy makers not to institute policy that does not include a dialogue with those whose lives are directly affected by the policies developed (Cosgrove, 2000; Lather & Smithies, 1997.) They may encourage policy makers to start with the psychiatric y ill and build their consultation practices outwards from there, rather than employing tokenistic and powerless consultation practices with their target population (Ballard, 1994; Oliver, 1989b, 1997.) Life-story research can help to counter the depersonalisation of much policy and practice (Ballard, 1994) and provide insight and possible hypotheses that can then be used in future research (Roberts, 2002.)

The qualitative methodology used for the present research uncovered a complex reaction by the participants to experiencing mental distress and its impact on careers. Data analysis of individual women’s experiences, their meaning-making and their self-concept, gathered through this research, will contribute to a more in-depth understanding of experiencing mental distress in a culture of compulsory employment. This may provide practical guidance to career guidance professionals and rehabilitation workers. Social ‘realities’ such as mental distress or psychiatric illness can only be understood through the ‘paradigmatic assumptions’ that exist in any particular cultural milieu (Kuhn, 1970). Such

paradigmatic assumptions hold humans together and make up the underlying meanings upon which society is created at any given time and in any particular location. In terms of the present research, the paradigmatic assumptions at play around psychiatric illness and careers are based on Western assumptions of progress, medical and social discourses around psychiatric illness and disability, and cultural readings of mental distress as pertaining to the outsider or the 'other.' All of these assumptions and discourses can be read as being maintained by 'linguistic convention' (Eagleton, 1983) and symbolic interaction (Blumer, 1969) by the women in the present research in the social world they experience.

The women in the present research all had their careers interrupted by their psychiatric illnesses. It may have been that the best thing for a speedy recovery for the women who told their stories in the present research would have been to return to their original jobs, and to have continuity of work environment, occupational choice and financial status. All of this would necessarily have taken a lot of support, a range of accommodations and willingness from the employing organization. It would have also required the workplace to provide the person with a suitably empathetic and organizationally powerful key support person on-site to help work through the process the individual needed to go through in order to return to work. Workplace education about accommodations for psychiatric ally ill people is to be recommended. This ought not to be a blanket education programme but rather a targeted response programme with specific identified workplaces that have the employment issue of an employee returning to work after illness or remaining at work during illness. Furthermore, ongoing workplace liaison – with both the person experiencing psychiatric illness and the employer – by mental health workers would be beneficial.

What is clear from the data in the present research is that, while independence and health seem to be linked with self-determination and autonomy to a degree, it is still exercised within a web of interdependency. This web can consist of traditional family and community. In the case of many of people with psychiatric illness, this can, however, sometimes be found lacking in those settings, so that a fellow-traveller type 'kinship' occurs

(Oliver, 1989) with others who experience mental distress. In the absence of friends in the life of the psychiatrically ill person directly after a psychiatric intervention and on into the foreseeable future, it would seem appropriate that the work of Ministry of Health funded community support workers and Workbridge's employment support fieldworkers be clearly seen as important tools in the vocational recovery process of an individual with psychiatric illness and that this work should be supported and strengthened.

What seems to be essential for maintaining wellness (and constitutes a 'truth' for them) in the narratives of the women in the present research, is a suite of services to call upon – the entire range of services available in the mental health sector - so that a key individual does not become the sole responsibility for recovery and resilience-development or relapse. This is a different model from that of the necessary key person in the workplace that is recommended by the findings of the present research on workplace support. That does not mean that a key person would not be invaluable in a mental health setting too, providing a single point of co-ordinated support, but given that achieving this is harder due to time and staffing constraints as well as policy and practice issues, this may not be essential.

9.11 Implications for researchers

Issues of power must be considered in any critical social science research (Griffiths, 1998.) What appears to have happened in the past few decades for women in Aotearoa/New Zealand who experience psychiatric illness is a shift in power away from the medical profession and towards people experiencing psychiatric illness and those who support them in the community. This is not to say that many issues of disempowerment do not still exist. Power relations will always exist (Foucault, 1977, 1980) but perhaps power has shifted away from the State to a degree and this provides more agency for the individual in today's social climate. This new empowerment sits nevertheless alongside strong acceptance of medical

models of health and disability and respect for professional's diagnostic abilities. An unpacking of the power issues operating in such dynamics would warrant further research.

The narratives acquired from non-P•keh•/non-palagi women on mental distress and career development would probably have been quite qualitatively different from those of most of the participants in the present study in significant ways relating to minority ethnic status and cultural models of health and community. Therefore, the present study must be received with this in mind. It nevertheless provides a useful platform to compare and contrast future studies on M•ori and Pasifika women's issues with predominantly P•keh•/palagi women's issues. For this reason, while it was personally disappointing and contrary to expectations that the present research would deliver a diverse cultural mix of participants, it is perhaps useful that it did not.

Furthermore, while the narratives of the women in the present research are those of Western women, they are also those of New Zealand women in a bicultural nation with a politically strong Indigenous population. Not many traces of this come through in the women's narratives but M•ori are identified as having positive impact on the recovery and resilience-development of some of the women. An explicit study of the influence of M•ori upon P•keh•-dominated health policy and practice and the influence of biculturalism upon the health and recovery/resilience-development discourses of people with psychiatric illness in Aotearoa/New Zealand is to be recommended. It would also be interesting to see what qualitative differences would occur if similar studies to the present research were undertaken in Australia, Canada or the United States. These are Western countries that have their own Indigenous populations with their own models of health and illness and their own struggles with biculturalism and colonisation. Australia, like Aotearoa/New Zealand, has had a long running psychiatric illness anti-discrimination campaign and it may be that both countries have benefitted similarly. Certainly, for the women in the present research, their narratives report many positives and opportunities for people experiencing psychiatric illness in Aotearoa/New Zealand in the new millennium, as well as the more commonly heard

negatives about barriers for the psychiatrically unwell in terms of full social participation as citizens.

Aspects of a person's life, as divulged in their narrative/story, are always shaped by the meaning-making of the individual in their ecological context (Bujold, 2004.) Our lives are multi-storied and have various layers of meaning (McMahon & Patton, 2006.) For this reason, it is my belief, as a sociologist, that it is imperative that the career researcher look at participants' narratives to explore the narrative 'self' rather than just the psychometric 'self' (Peavy, 1998.) It is important to be biographers rather than mere actuaries quantifying traits (Savickas, 1992.) It is also important that contextual variables such as ethnicity, gender and socio-economic status are taken into account alongside personal variables such as interests (Brown, 1996; Patton & McMahon, 1999), particularly with a view to being sensitive to the role of dominant Western, white, middle class constructs in individuals' stories, for example, the 'myth' that careers are linear, stable and usually based around one occupation and one organisation (Fitzgerald & Betz, 1994; Leung, 1995; Savickas, 2003.)

9.12 Conclusion

This was an exploratory study of the subjective experience of the impact of mental distress on women's career development. The aim of this study was to allow the women to narrate their own story of mental distress and career development with only an initial prompt at the opening of their interview, though topics were probed in later interviews as a distinct grounded theory emerged. Different data would have been produced by a hospital study or by a survey, and such studies would be valuable adjuncts to this one, extending the knowledge-base around careers issues and psychiatric illness in Aotearoa/New Zealand.

The theory generated by the present research has been produced using social scientific methods. It is sufficiently robust to be used both to inform policy, as a platform for future research, and to strengthen professional career practice. Therefore, this research will

be beneficial in two ways: it has practical application for New Zealanders (policy makers, women's health groups, employers, mental health groups, employment agencies, schools and the general public), and, intellectually, it brings more to the academic argument about careers and psychiatric illness.

The culture in which the participants lived has been internalized by them to a greater or lesser extent and affects the narratorial 'truth' they give. Rather than being an entirely factual historical schedule of events in their lives, their stories have a 'truth' based in narrative, inflected by their opinions and beliefs, their desire to be helpful to me as a researcher, the mindset in which they operate, and their 'take' on the world that is bound up with the worldview of the culture in which they live (Ho, 1995; Williams, 2003.) The historical 'truth' is less important than the meaning generated by the narratives of the participants in the study. As Savickas (1995, p. 22) puts it: "their definitions do not mirror reality; they inscribe it." Put another way:

Whether truth or time actually exists ultimately doesn't really matter. We spend our lives searching, in some way or another, for truth. Like time, the concept of truth organizes our lives, gives us a sense of meaning, and creates the fundamental notion of 'progress.' Perhaps time and truth are not real but they are crucial to our psychic survival. (McPhee, 2001, p. 36)

PART F – APPENDICES

Appendix A - Information Sheet

[University of Canterbury Department of Education letterhead]

INFORMATION SHEET

You are invited to be involved as a participant in the research project: 'A Grounded Theory of Career Development in the New Zealand/Aotearoa Context.' This project is being carried out as part of a requirement for a PhD by Annie Roma Southern under the supervision of Drs Judi Miller, Diane Pearce and Kristi Durbin at the University of Canterbury. Your involvement in this project will entail participation in an interview about your perspective on your career/worklife. During the interview, which should take approximately one hour in a suitable room at university or at a location of your choice, I may ask you to complete a timeline and a family tree to help clarify your interpretation. The interview will be audio-taped and you have the right to stop the tape (and/or the interview) at any time. You will be given your transcribed interview to review and/or amend. You also have the right to withdraw from the project at any time, without providing me with a reason for doing so. Your withdrawal will mean the withdrawal of all information provided by you. The results of the project may be published in journal articles or in conference presentations, but you may be assured of complete confidentiality of data gathered in this investigation and anonymity in any written material: the identity of research participants will not be made public without prior consent. To ensure anonymity and confidentiality pseudonyms will be used and any identifying features will be altered. If you have any queries about the research or your participation, please contact me at ago18@student.canterbury.ac.nz. Alternatively, you can also contact my supervisor at the School of Education, Canterbury University on 03-366 7001 or by email at judi.miller@canterbury.ac.nz. The project has been reviewed and approved by the University of Canterbury Human Ethics Committee.

Appendix B - Consent Form

[University of Canterbury Department of education letterhead]

Annie Roma Southern MA, GDLT, CertHE

Email. ago18@student.canterbury.ac.nz

Ph. 364 2987 ext 8807

CONSENT FORM

Mental Illness and Women's Career Development

I have read and understood the description of the above-named project. On this basis I agree to be involved as a participant in the project, and I consent to publication of the findings of the project with the understanding that my anonymity will be preserved. I understand also that I may at anytime withdraw from the project, including withdrawal of any information I have provided.

NAME: (please print)

Signature:

Date:

Appendix C - Transcript Covering Letter

Dear XY

Here finally is the transcript for your approval. You will notice that I have removed some names and other features for confidentiality and anonymity reasons. Please make amendments if you need to and sign the bottom of each page to indicate that you have seen it and approved it as the final transcript. I have provided a stamped addressed envelope for you to return it in. I shall, of course, post you a copy of the final transcript once I have inputted any amendments you have made so that you have a copy to keep.

Thanks again for your participation in my research. It was a really great interview and I gained a lot from it.

Best wishes.

Annie Southern

Appendix D - *Balance New Zealand Conference 2005* Flyer

What does being a participant involve? It involves telling your story of your bipolar disorder and your experience (or lack of it!) of work, employment or your career – whatever you like to call it – whether unpaid, voluntary, involuntary, home-based, paid, fulltime, part-time, seasonal or occasional to a researcher who also has an experience of mental illness. It involves an interview of between 45minutes and 1 hour 15 minutes duration at a place and time to suit you. The interview is audio-taped and then transcribed so that you can check what you said and delete, add or change anything you said. Only your approved 'transcript' (typed up version) of your interview is used for the study. The audiotape is destroyed once the transcript is finalized by you. You choose a pseudonym (nickname/false name) so that the transcript does not have your name on it and your name does not appear in the final report. You can also change any identifying details such as people, companies, and personal attributes so that your story is anonymous (ie, you are not identifiable) if you wish.

What will happen to my story if I become involved? It will be used with other peoples' stories to build a picture of the issues around employment, work and careers for New Zealanders who have a diagnosis of bipolar disorder. Examples from stories will be used in the final written version of the doctoral report to show various themes which have emerged as issues for New Zealanders with a diagnosis of bipolar disorder. If the doctoral research (the undertaking of a large piece of research at PhD level) is successful, a thesis (report) will be placed in the Library of Canterbury University and the School of Education Library at Canterbury University. People will be able to use it for future research and for assignments in areas such as social work, psychology, education and sociology. The report may be published as a book (in which case a copy would be available from the Mental Health Education and Resource Centre library in Christchurch and other bipolar support groups and libraries around New Zealand.) Articles might be published in journals. A booklet might be produced for employers and employees. Organizations may ask to read it to help them in their work in mental health and employment. The research will play its part in improving options for people with bipolar disorder in the world of work.

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Glossary of M• ori Terms

Aotearoa	Literally 'land of the long white cloud'; New Zealand
h• pu	Sub-tribe – generally considered a subdivision of an iwi
hikoi	Walk; protest march
hui	Gathering of people
hui	Main tribal group
kaupapa M• ori	Based on M• ori principles
iwi	Tribe
kawanatanga	Governorship; sovereignty
k• rero	Talk; story; conversation
mahi	Work; occupation; activity
makutu	Curses being placed on someone who has transgressed against someone
M• ori	Literally normal or ordinary but has become a generic term used to describe a person who is Indigenous to New Zealand
mana	Power – particularly spiritual; prestige; authority; status
manuhiri	Visitor; guest
marae	Courtyard/a place for public debate/ceremonial gathering place
Mate • tua	Supernatural affliction requiring spiritual healing and resistant to P• keh• medicine.
mate M• ori	Literally 'M• ori disease'; it is believed that the gods of disease punish any infringement of tapu by attacking the transgressor's family in some way with an illness. P• keh• medicine is not considered able to relieve such an affliction and traditional methods are still used today often alongside Christian spiritual healing.
Moriori	Tribe of people purported to be settled in Aotearoa/New Zealand prior to the arrival of the M• ori canoes
P• keh•	A non-M• ori – often used to describe New Zealanders of European descent
tangata whenua	People of the land; host group; Indigenous culture
tapu	Sacred
tauiwi	Foreigner; someone (neither P• keh• nor M• ori) who was born overseas
Te Reo M• ori	The M• ori language (recognised as one of the official languages of Aotearoa/New Zealand) in 1987
tikanga M• ori	M• ori customs
te ropu kaitautoko	Support people
<i>Te Tiriti of Waitangi</i>	<i>The Treaty of Waitangi</i> ; signed by the M• ori tribes and the British Crown in 1840, it was an invitation by M• ori for non- M• ori to share the land with them and spoke of peace, justice, kawanatanga (governorship), rights of both peoples and the ongoing tino rangatiratanga (self determination) of M• ori as a people. It was unfortunately not honoured by the Crown and led to injustices, a war and more recently protest hikoi, land occupations, reparation claims before the Waitangi Tribunal and the formation of a M• ori political party.
tino rangatiratanga	Self determination
tipuna	Ancestors
tohunga	Healer
whakam•	Shame
whakapapa	Genealogy; descent lines; ancestry
wairua	Spirit
whakatauk•	Proverb or saying
wh• nau	Extended family

